Hospital Progress

February, 1956

IN TWO PARTS

VOLUME 37 • NUMBER 2

PART I

INCLUDING

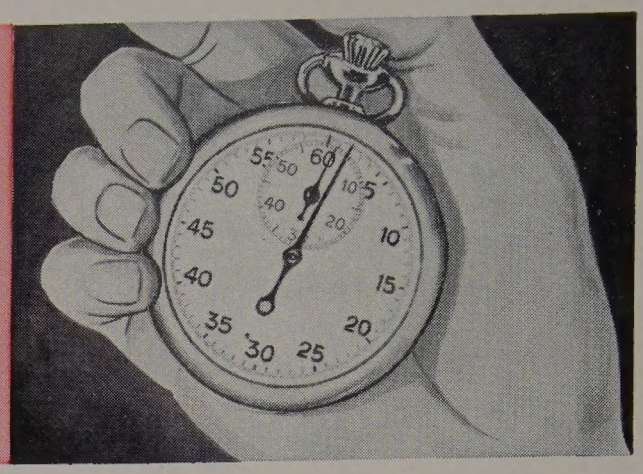
- O. R. SAFETY
- THE PURCHASING FUNCTION
- CONSTRUCTION & MAINTENANCE

PLUS

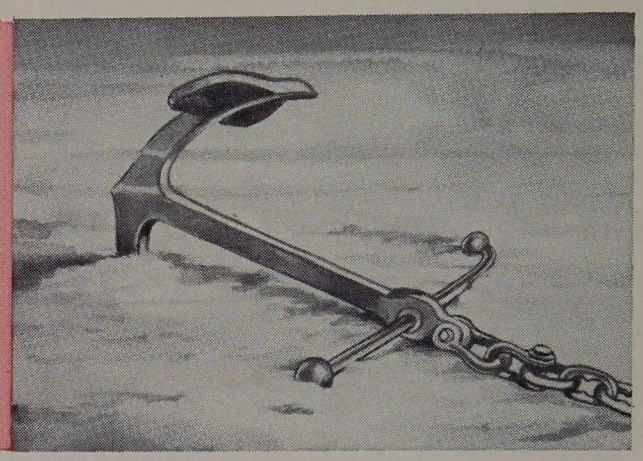
- DEPARTMENTAL FEATURES

OFFICIAL JOURNAL
OF THE
CATHOLIC HOSPITAL ASSOCIATION

1 *Sticks Quick*



2 *Stays Put*



3 *Removes Clean*

LESS-IRRITATING SEAMLESS PRO-CAP ADHESIVE PLASTER

You pull Pro-Cap off the roll. It tears easily, *sticks quick*. Days later it still holds its position on the skin—no slipping, no creeping, it *stays put*. When you take it off there is virtually no "clean up" necessary. It *removes clean*.

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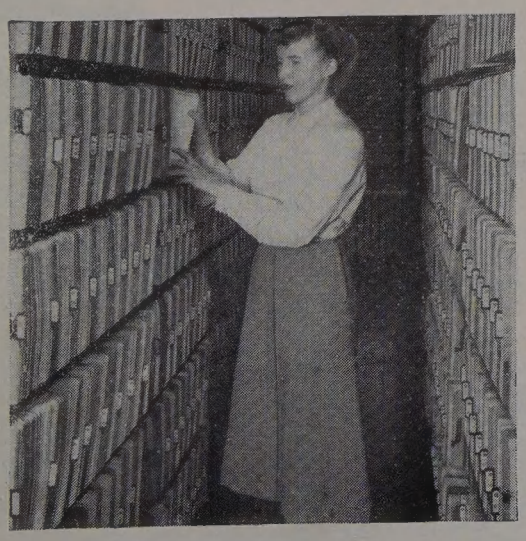
Extra drawer Kompakt Files at the St. Francis Hospital, Topeka, Kansas, saved costly filing floor space while increasing filing capacity 25 percent. New 6-drawer Kompakt Files, replacing conventional 5-drawer files of the same height, substantially increased the number of records stored within the same area. Built into the wall of the Medical Records Room, these handsome, "Gray-Rite" finished cabinets blend harmoniously with any color scheme.

Kompakt – *the file with the extra drawer* – has smoother operation...modern, streamlined appearance . . . greater strength, rigidity and durability! Get extra filing capacity in your Medical Records Room with *extra drawer* Kompakts. Circle LBV676.

Shelf Filing Expands Medical Records Room



Installation of Remington Rand Shelf Filing in the Medical Records Library of Firmin Desloge Hospital, St. Louis, Missouri, made room for a 33 percent expansion. Besides the great space-saving advantage of Shelf Filing, they found records filed on shelves are much more accessible, easier to file and find. Overall results: more efficient administrative procedures; reduced operating costs. Circle LBV626.

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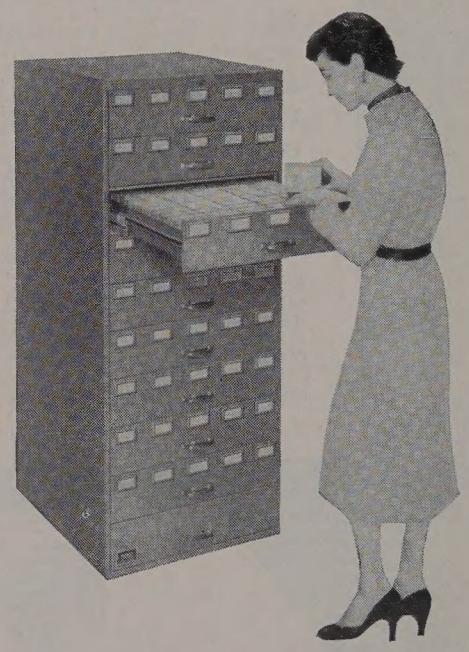

in a single filing cabinet in the Record Room. Get all the facts on this interesting case history. Read how this hospital met today's demands for more room to conduct a constant broadening program of activities. Circle CH984.

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H-13

Therapeutic Briefs

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VALMID

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Nonbarbiturate sedative with a four-hour action span. The very short action means bright awakening without "hang-over," drowsiness, or depression. 'Valmid' also offers a wide margin of safety.

Supplied as Tablets 'Valmid,' 0.5 Gm. (7 1/2 grains) (scored), in bottles of 100 (1799).

WHEN SEDATION MUST BE QUICK YET SUSTAINED

TUINAL

Combines in a single pulvule equal parts of quick-acting 'Seconal Sodium'* and moderately long-acting 'Amytal Sodium.'†

Supplied in three convenient dosages of 3/4, 1 1/2, and 3-grain pulvules.

*'Seconal Sodium' (Secobarbital Sodium, Lilly)
†'Amytal Sodium' (Amobarbital Sodium, Lilly)

FASTEST AND SHORTEST-ACTING BARBITURATE

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A proved favorite among physicians in the treatment of simple insomnia, unruly pediatric patients, and obstetric patients and in procedures associated with moderate pain.

Supplied in pulvules, ampoules, suppositories, powder, and 'Enseals' (Timed Disintegrating Tablets, Lilly).

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Its usefulness extends into the fields of clinical medicine, surgery, anesthesiology, psychiatry, and many other specialties. A safe and predictable sedative-hypnotic.

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FEBRUARY, 1956

SPECIAL FEATURES

DEPARTMENTS

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of the United States and Canada

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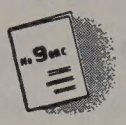
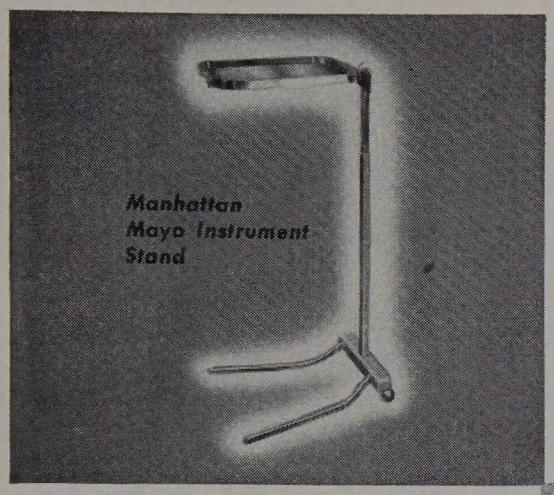
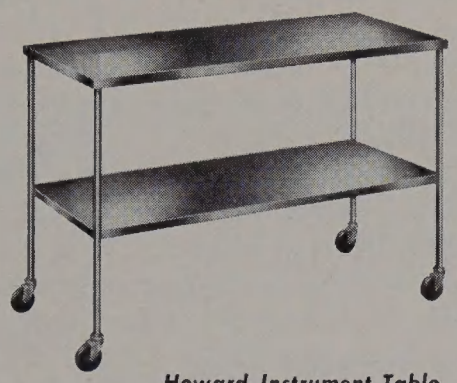


SEND FOR BULLETIN 9 ORC . . . . illustrates and describes more than 50 different Blickman-Built stainless steel units of operating room equipment.

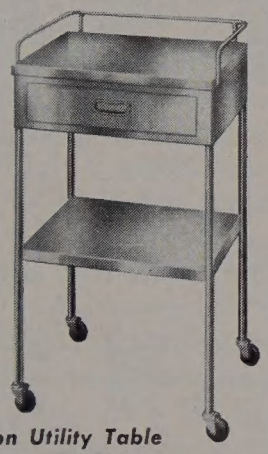


Manhattan Mayo Instrument Stand



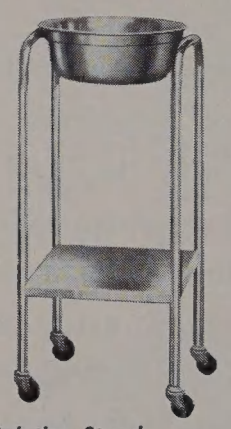
Howard Instrument Table

Clifton Revolving Stool



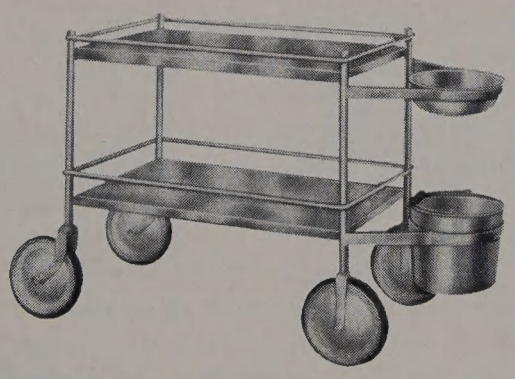
Ferguson Utility Table

Graystone Curved Instrument Table

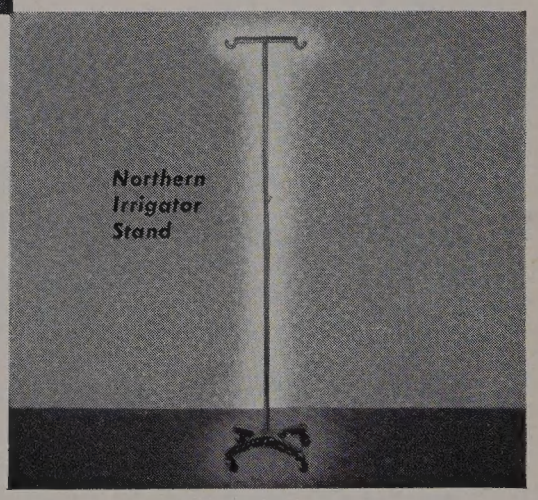


Baker Solution Stand

Kellogg Sponge Rack



Dawson Dressing Carriage



Northern Irrigator Stand

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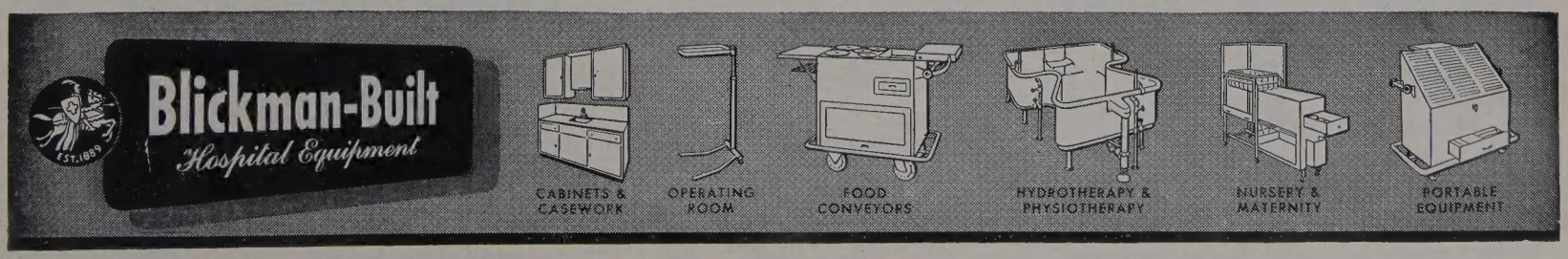
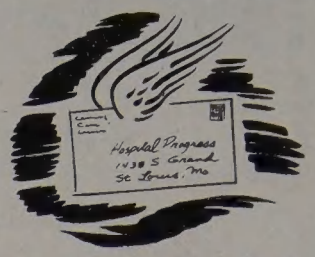


You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 26-28.

LETTERS TO THE EDITOR



To the Editor:

Very many thanks for giving the Medical Mission Sisters a place in HOSPITAL PROGRESS. We are indeed honored to have a story in your fine publication. I feel sure that it will mean much for the Society and we are grateful for your interest and your kindness.

I do not know when your type is torn down but we are wondering if it might not be possible to have a reprint of the article. Some requests do come to us fairly often for information about mission nursing and a reprint of this article might be helpful.

Thank you again for all your kindness to us on many occasions. We are grateful to all at the Catholic Hospital Association office. Please do give them our thanks and best regards.

Gratefully in Christ,
SISTER MARY RICHARD, S.C.M.M.

Medical Mission Sisters
Philadelphia, Penn.

★

To the Editor:

I wish to acknowledge and thank you for your letter referring to the story about the Sisters of Mercy in Chacachacare [December, 1955, p. 48].

When you requested an article concerning the overseas activities of our Sisters, I prepared the material about the Sisters of Mercy of the Province of Baltimore who were working in the leprosarium at Chacachacare. The other material, however, about the leprosarium at Mahaica, British Guinea, was supplied by Mother M. Celestine McHale, R.S.M., Mother Provincial of the Province of Scranton. The Sisters of our Scranton Province are in Mahaica. I am sending you this information so that should there be any question of publication, Mother M. Celestine would be named as the writer of the article and Provincial of the Sisters laboring in Mahaica.

The article in HOSPITAL PROGRESS was very attractively presented, and I appreciate your sending me a few sets of tear sheets of this article.

Sincerely,
MOTHER M. STELLA MARIS, R.S.M.
Mother Provincial

Sisters of Mercy
Mt. Washington, Baltimore, Md.

★

To the Editor:

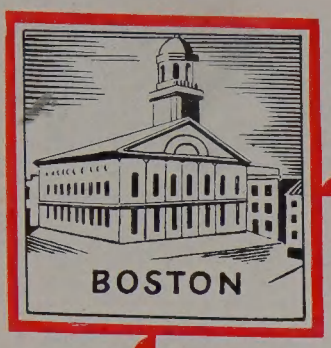
Naturally I am delighted that you have made use of the material about the McAuley Clinic [December, 1955, p. 44] because I feel obligated to promote the establishment of psychiatric facilities in general hospitals.

My only regret is that the fair city named after St. Francis of Assisi is referred to as "Frisco" in the title. As Herb Caen has said in his book, "Don't Call It Frisco," because it "reminds the city uncomfortably of the early brawling, boisterous days of the Barbary Coast . . . and because 'Frisco' shows disrespect for a city that is now big and proper and respectable. And because only tourists call it 'Frisco,' anyway, and you don't want to be taken for a tourist, do you?" But perhaps it is only we sensitive residents of San Francisco who are offended by the nickname.

The members of the board of directors of the San Francisco Foundation are always pleased to have their grants publicly acknowledged and so is the Deputy Director of Mental Health of the State gratified when the support of National Mental Health Funds is mentioned. The members of the budget study committee of the Community Chest like people to know what agencies are Chest supported. It would be most convenient for us to be able to distribute copies of the article from HOSPITAL PROGRESS to these people as well as to those who periodically request information about the clinic.

Sincerely yours,
SISTER M. DOLORITA
Administrator

McAuley Clinic of St. Mary's Hospital
San Francisco, Calif.



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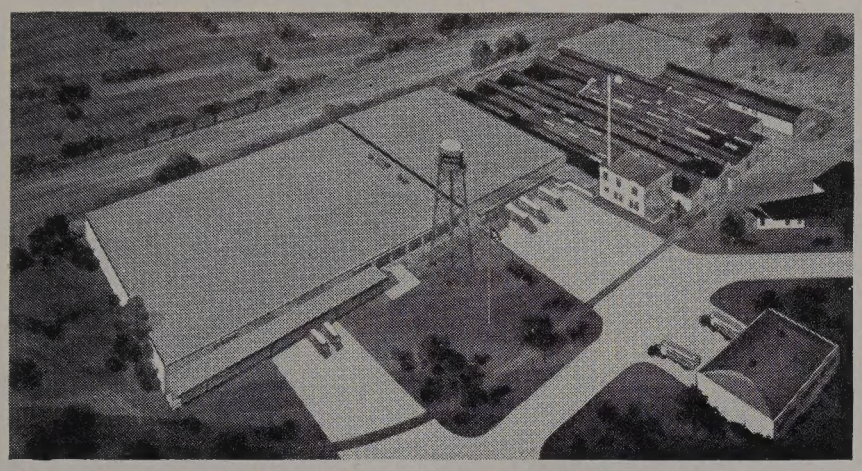

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CALENDAR
OF EVENTS TO COME

FEBRUARY

Conference on Nursing Education (sponsored by the Conference of Catholic Schools of Nursing), Houston, Tex. **9-11**

Conference on Canon and Civil Law for Catholic Hospitals, Mayflower Hotel, Washington, D.C. **15-18**

MARCH

Conference on Hospital Accreditation (sponsored by The Catholic Hospital Association), Spokane, Wash. **5-6**

Wisconsin Conference of Catholic Hospitals, Memorial Union, Marquette University, Milwaukee, Wis. **13-14**

Conference on Medical Social Service and Hospital Accreditation (sponsored by The Catholic Hospital Association), Mercy Hospital, Pittsburgh, Pa. **20-21**

APRIL

Blood Banking Workshop (sponsored by The Catholic Hospital Association), Georgetown University, Washington, D.C. **2-6**

National Catholic Educational Association, St. Louis, Mo. **3-6**

Texas Conference of Catholic Hospitals, Dallas, Tex. **6**

Institute on Supervisory Training (sponsored by The Catholic Hospital Association), Seattle, Wash. **20-21**

Iowa Hospital Association, 27th Annual Meeting, Hotel Savery, Des Moines, Ia. **26**

MAY

Massachusetts Hospital Association, Annual Meeting, Hotel Statler, Boston, Mass. **10**

American Nurses Association, Chicago, Ill. **14-18**

Conference of Catholic Schools of Nursing, 9th Annual Meeting, Milwaukee, Wis. **19-20**

Catholic Hospital Association, 41st Annual Meeting, Milwaukee, Wis. **21-24**

JUNE

American Medical Association, Chicago, Ill. **11-15**

First North American Conference of Medical Laboratory Technologists, Hotel Chateau Frontenac, Quebec City, Quebec, Canada **17-22**

Second Congress of the World Confederation for Physical Therapy, Hotel Statler, New York City, N.Y. **17-23**

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the first safe antifungal antibiotic

VAGINAL TABLETS

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100,000 units of Mycostatin per gram. 30 Gm. tubes.

OINTMENT

ORAL TABLETS

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THIS MONTH *with the Association*

Annual Executive Board Meeting

On Monday, January 16, the annual meeting of the Executive Board of the Association took place at the new St. Charles Hospital in Toledo, Ohio as guests of the President of the Association, Msgr. Robert A. Maher, Director of Catholic Hospitals for the diocese of Toledo. This year's meeting followed the pattern of previous annual Board meetings inasmuch as the Board considered such operating matters as the annual financial report, the budget for 1956, the forthcoming Convention, reports of the activities of the Association's Councils and Committees, etc. Other matters of current interest were also reviewed by the Board.

In addition to Monsignor Maher, the following members of the Executive Board attended: *Past-President*—Msgr. E. J. Goebel, Milwaukee, Wis.; *President-Elect*—Msgr. Joseph Brunini, Jackson, Miss.; *1st Vice-President*—Msgr. J. B. Toomey, Syracuse, N. Y.; *2nd Vice-President*—Very Rev. A. R. Peschel, Casselton, N.D.; *Secretary*—Mother Bernard Mary, St. Francis Hospital, Hartford, Conn.; *Treasurer*—Sister Agnes of the Sacred Heart, Providence Hospital, Seattle, Wash.; Mother M. Hilary, Sacred Heart Academy, Ogden, Utah; Sister M. Brigh, St. Mary's Hospital, Rochester, Minn.; Sister Loretto Bernard, St. Vincent's Hospital, New York, N.Y.; Sister M. Veronica, Blessed Martin de Porres Hospital, Mobile, Ala.; and Sister Sheila, St. Joseph's General Hospital, North Bay, Ontario, Canada. Unfortunately, Sister Jarbeau, St. Boniface Hospital, St. Boniface, Manitoba, Canada, was unable to attend.

Rev. John J. Flanagan, the Executive Director, and Msgr. D. A. McGowan, Director of the Bureau of Health and Hospital of the National Catholic Welfare Conference, also attended.

Administrative Board Meets in Toledo

On Tuesday, January 17, at St. Charles Hospital in Toledo, Ohio, the regular meeting of the Administrative Board of the Association took place. Presiding was His Excellency, Bishop William A. O'Connor, Episcopal Chairman.

In addition to the members and officers of the Executive Board, the following also attended: Msgr. F. M. J. Thornton, Sea Girt, N.J.; Msgr. A. C. Dalton, Dorchester, Mass.; Rev. Armand Rotondi, Plainfield, Ill.; and Msgr. J. F. Luker, Ogdensburg, N.Y.

Concerned as it is with matters relating to legislation, public relations and public policy, the Administrative Board reviewed a number of problems in this area. Several touched on reimbursement policies while others concerned legislation. Educational programs were also reviewed.

Mid-Winter Meeting Bishops' Representatives

Msgr. R. A. Maher of Toledo, President of the Association, was host to the 11th Annual Mid-Winter Meeting of the Conference of Bishops' Representatives for Hospitals on behalf of His Excellency, Bishop Rehring of Toledo. Under the episcopal chairmanship of His Excellency, Bishop O'Connor, this annual meeting was convened on Wednesday and Thursday, January 18 and 19 at the Commodore Perry Hotel. This year's program focused attention upon accreditation, a review of certain legislative developments as well as trends in the development of hospital services. Attending this year's meeting were:

Bishop's Representative	*Archdiocese*
Rt. Rev. Msgr. John J. Duggan	Baltimore
Rt. Rev. Msgr. A. C. Dalton	Boston
Rt. Rev. Msgr. John W. Barrett	Chicago
Rev. J. V. Moscow	
Rev. Wm. Hackett	Cincinnati
Rt. Rev. Msgr. J. R. Mulroy	Denver
Rev. F. J. Kaufmann	Dubuque
Rev. L. E. Skelly	Hartford
Rt. Rev. Msgr. E. J. Goebel	Milwaukee
Rt. Rev. Msgr. T. J. Conroy	Newark
Rt. Rev. Msgr. H. J. Jacobi	New Orleans
Rev. P. J. Frawley	New York
Rev. J. J. Foley, S.J.	Omaha
Rev. J. B. Winter	St. Louis
	Diocese
Rev. J. F. Pritchard	Albany
Rev. C. G. Schindler	Belleville
Rev. A. J. Galowitsch	Bismarck

(Continued on page 14)

Rev. J. H. Fitzpatrick	Brooklyn
Very Rev. Msgr. J. M. McPherson	Buffalo
Very Rev. Msgr. A. W. Jess	Camden
Rev. J. J. Humensky	Cleveland
Very Rev. Msgr. W. E. Kappes	Columbus
Rt. Rev. Msgr. C. A. Towell	Covington
Rev. A. J. Lemire	Crookston
Very Rev. A. R. Peschel	Fargo
Rev. Armand Rotondi	Joliet
Rev. John W. Kordsmeier	Little Rock
Rev. J. R. McGreal	Manchester
Rt. Rev. Msgr. J. J. Raleigh	Mobile-Birmingham
Rt. Rev. Msgr. J. Brunini	Natchez
Rt. Rev. Msgr. Joseph F. Luker	Ogdensburg
Rev. Wm. Erkens	Pittsburgh
Rev. R. G. Stewart	Rockford
Rev. Francis A. Jurek	Saginaw
Rt. Rev. Msgr. J. L. Gatton	Springfield, Ill.
Rev. Frank Dirksen	
Very Rev. P. L. Richter	Steubenville
Rt. Rev. Msgr. F. M. J. Thornton	Trenton
Rev. J. P. Gallagher	Youngstown

Rt. Rev. Msgr. D. A. McGowan, Executive Director of the Conference, and Director of the Bureau of Health and Hospitals of the National Catholic Welfare Conference, Washington, D.C., also attended.

Winter Meeting Arkansas Conference

The Arkansas Conference of Catholic Hospitals met on December 15 at St. Vincent Infirmary, Little Rock. Sister Rita Rose, Administrator of Rogers Memorial Hospital, Rogers, presided at the Conference which was attended by representatives from the 12 Catholic hospitals of the state.

During the morning session, which was devoted to business, Rev. John W. Kordsmeier, Diocesan Director of Catholic hospitals, reported to the Conference on hospital matters, local and national, as they have been considered by the various hospital group meetings which he has attended. Following the morning session, the Sisters were honored by the presence of His Excellency, Bishop Fletcher, at luncheon served by St. Vincent's. His Excellency addressed the Sisters with words of inspiration and encouragement for continuing their great work in the Catholic hospitals.

Mr. W. I. Christopher, Director of Personnel Services of the C.H.A. staff, provided for the Conference an excellent session on "Personnel Policies, Practices and Problems" during the afternoon. Mr. Christopher encouraged the hospital representatives to ask questions and submit problems, and response from those attending the Conference was most enthusiastic.

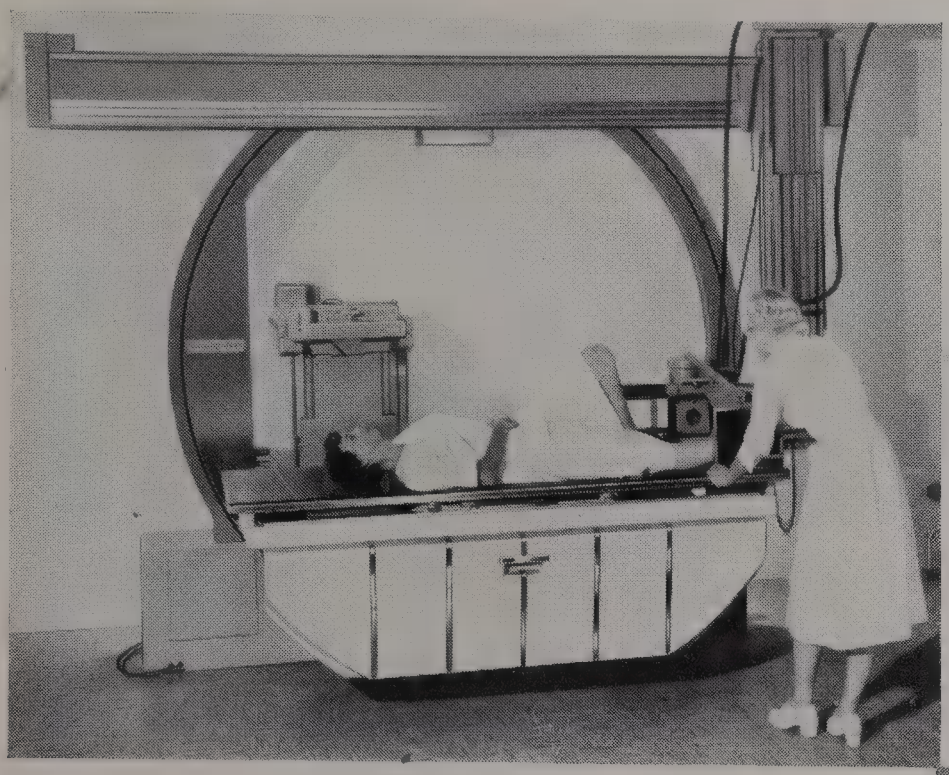
The following were appointed to complete the current term of office—*Vice-President*, Sister M. Columba, St. Mary's Hospital, Dermott and *Secretary*, Sister M. Mildred, St. Bernard's Hospital, Jonesboro.

New Jersey Conference Annual Meeting

The New Jersey Conference of Catholic Hospitals held its annual meeting on December 6th in the School of Nursing Auditorium of St. Peter's General Hospital in New Brunswick.

The present slate of officers were re-elected to office for 1956: *President*—Sister Clare Dolores, St. Vincent's Hospital, Montclair; *Vice-President*—Brother Theophane Lawrence, Alexian Brothers Hospital, Elizabeth; and *Secretary-Treasurer*—Sister M. Evelyn, Holy Name Hospital, Teaneck. The Executive Board of the Conference, composed of the Bishops' Representatives of the Archdiocese of Newark and the Dioceses of Trenton, Camden and Paterson are: Rt. Rev. Msgr. T. J. Conroy of the Newark Archdiocese as

(Continued on page 16)



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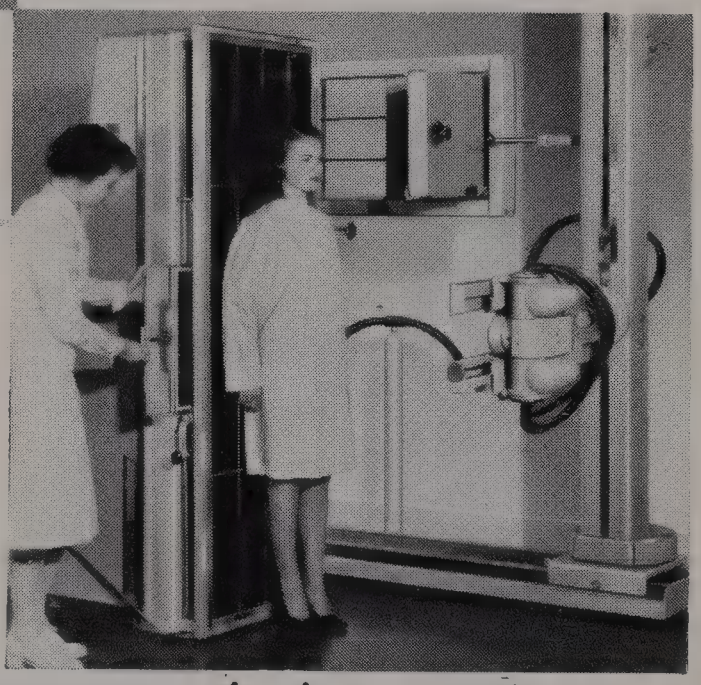

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Chairman; Rt. Rev. Msgr. F. J. Thornton of the Diocese of Trenton; Rt. Rev. Msgr. J. J. Shanley of the Diocese of Paterson; and Rt. Rev. Msgr. A. W. Jess of the Diocese of Camden.

Representatives of the 17 Catholic hospitals in New Jersey were present.

At the annual meeting, plans were initiated for a joint publicity campaign for National Hospital Week in 1956. Annual reports from all committees were read. Although this Conference is but a year old, it has achieved many of its aims and purposes. It has stimulated group thinking in relation to problems of hospital administration common to all hospitals. The representatives of all hospitals freely discuss their problems and seek ways and means based on the experience of other hospitals to reach an agreeable solution. By sharing experiences, the Conference has proven an extremely valuable means of education for all those who participate.

The meeting closed with a showing of the Association's film, "The Dedicated," purchased by the Conference.

Patron Saints

March 8 . . . Feast of St. John of God, Patron of Catholic Hospitals and the Sick, of Religious and Lay Nurses. Declared by Pope Leo XIII on June 22, 1886.

March 19 . . . Feast of St. Joseph, selected as Patron of Procurators and Business Office Workers.

Western Conference Organizes Annual Meeting

In preparation for the annual meeting of the Western Conference of Catholic Hospitals on April 22, Sister Agnes of the Sacred Heart, Providence Hospital, Seattle, a member of the program committee, reports that a Pre-Convention Institute is scheduled dealing with Supervisory Training including personnel considerations.

Another consideration will be "The Catholic Hospital in a Changing World." Some of the problems besetting hospitals during the past few years as well as trends in hospital development constitute the subject matter of this presentation. Another consideration will be the discussion of medical-moral considerations with emphasis on the general proposition that "Good Medicine is Good Morals." An effort is being made, too, to organize a question and answer period in which the Sisters will have an opportunity for general discussion of many of the particular problems which face them.

New Officers A.S.H.P.

Taking office at the forthcoming meeting of the American Society of Hospital Pharmacists in Detroit during the week of April 8 will be the following: *President-Elect*—Paul F. Parker, Chicago, Ill.; *Vice-President-Elect*—Milton Skolaut, Bethesda, Md.; and *Treasurer-Elect*—Sister M. Berenice, St. Mary's Hospital, St. Louis, Mo.

Mr. Parker is known to many of the pharmacists in Catholic hospitals for his outstanding work in this Society. Mr. Skolaut of the U. S. Public Health Service has addressed the Association's Pharmacy Institutes on more than one

(Concluded on page 19)

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occasion. Sister Berenice, Chief Pharmacist of St. Mary's Hospital, St. Louis, has served on the Association's Committee on Hospital Pharmacy Practice rendering distinguished service to the cause of hospital pharmacy practice.

A.A.M.R.L. Elects Sister M. Yvonne

At the recent meeting of the American Association of Medical Record Librarians Sister M. Yvonne of Firmin Desloge Hospital, St. Louis, Mo., was chosen First Vice-President of the medical records group. Sister Yvonne has been active in the field of medical record library science for many years. She has been active in the Missouri Society and has directed several institutes dealing with various phases of medical record library work.

The editors of HOSPITAL PROGRESS join in extending congratulations to Sister Yvonne.

A.A.H.A. Appoints William Pierce, Sr.

For several years the Board of Directors of the American Association of Hospital Accountants has been considering the extension of the activities of the Association and the development of a program which would more effectively advance the interests of hospital accounting. During the past year particularly, the re-organization of the Association to achieve this objective was brought about.

Mr. William M. Pierce, Sr., of Louisville, Ky., is the first full-time Executive Secretary to assume the responsibilities for developing and carrying out this program.

His record reveals considerable activity in the field of hospital work. Having become a member of the American Association of Hospital Accountants in 1952, Mr. Pierce became active in the Kentuckiana Chapter of the A.A.H.A. serving as its president. He was active in the co-ordinating program of the several Kentucky chapters of the A.A.H.A. He likewise holds memberships in the Hospital Conference of Metropolitan Louisville, in the Kentucky Hospital Association and in other groups. He has been a faculty member of the Institutes on Hospital Accounting held at Indiana University for the years 1954 and 1955. He has served in a like capacity as a faculty member in Kentucky institutes.

The editors of HOSPITAL PROGRESS and the staff of the C.H.A. extend congratulations to Mr. Pierce. ★

COMMENT

Various proponents of the Heredity vs. Environment schools (to explain "personality" and "character") can—as far as I'm concerned—go look at monkeys in the zoo *ad infinitum*. I hope they do.

Tradition alone is no guarantee of truth. Tradition is merely repeated acceptance of, or acquiescence in, something —whether that "something" is true or false.

★

Spiritual myopia can be permanently incapacitating; the physical affliction may be only transiently so.

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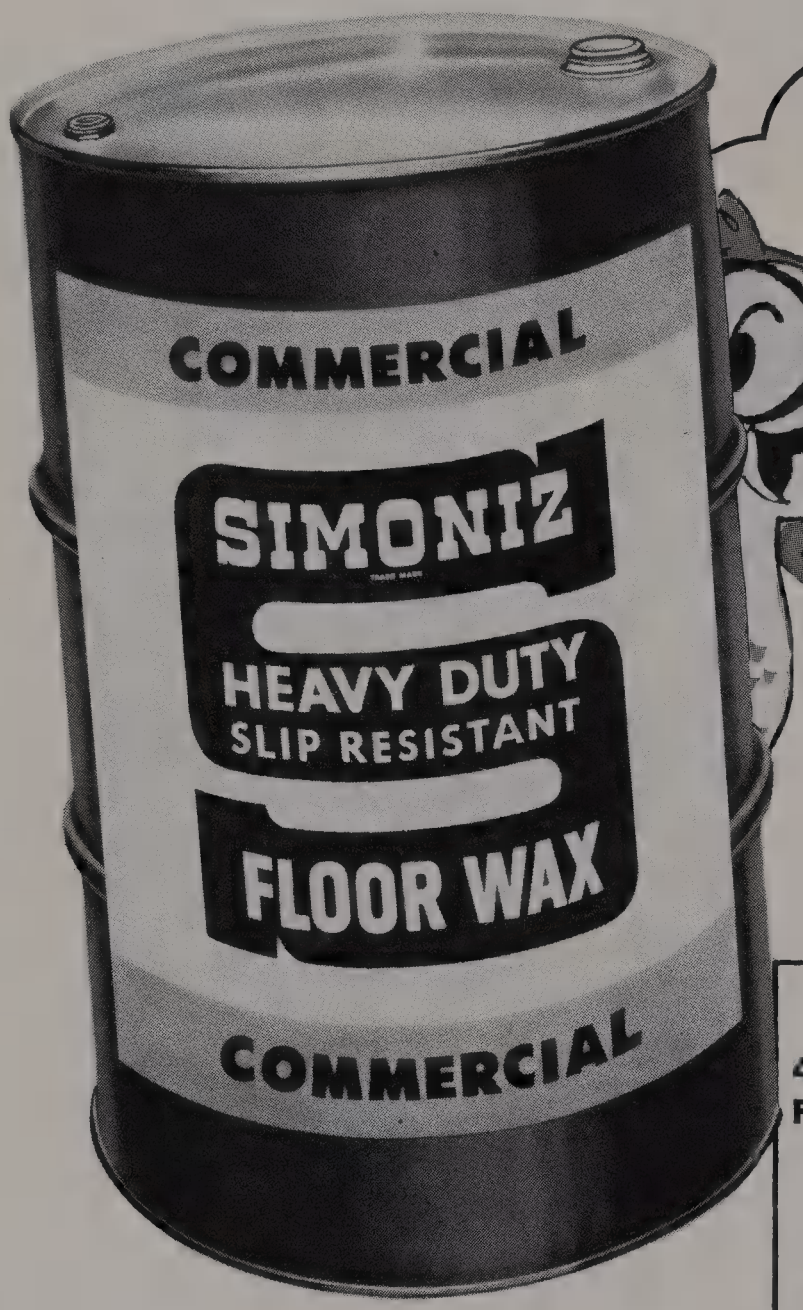

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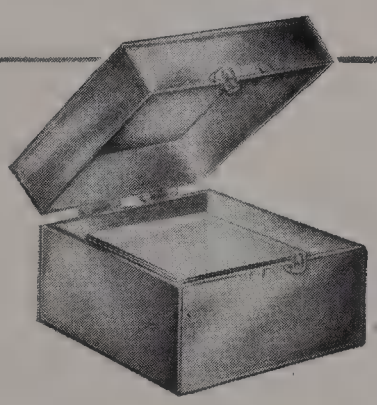

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*Schraub, C. F.: Bull. Am. Soc. Hosp. Pharm. *12*:144 (March-April) 1955.

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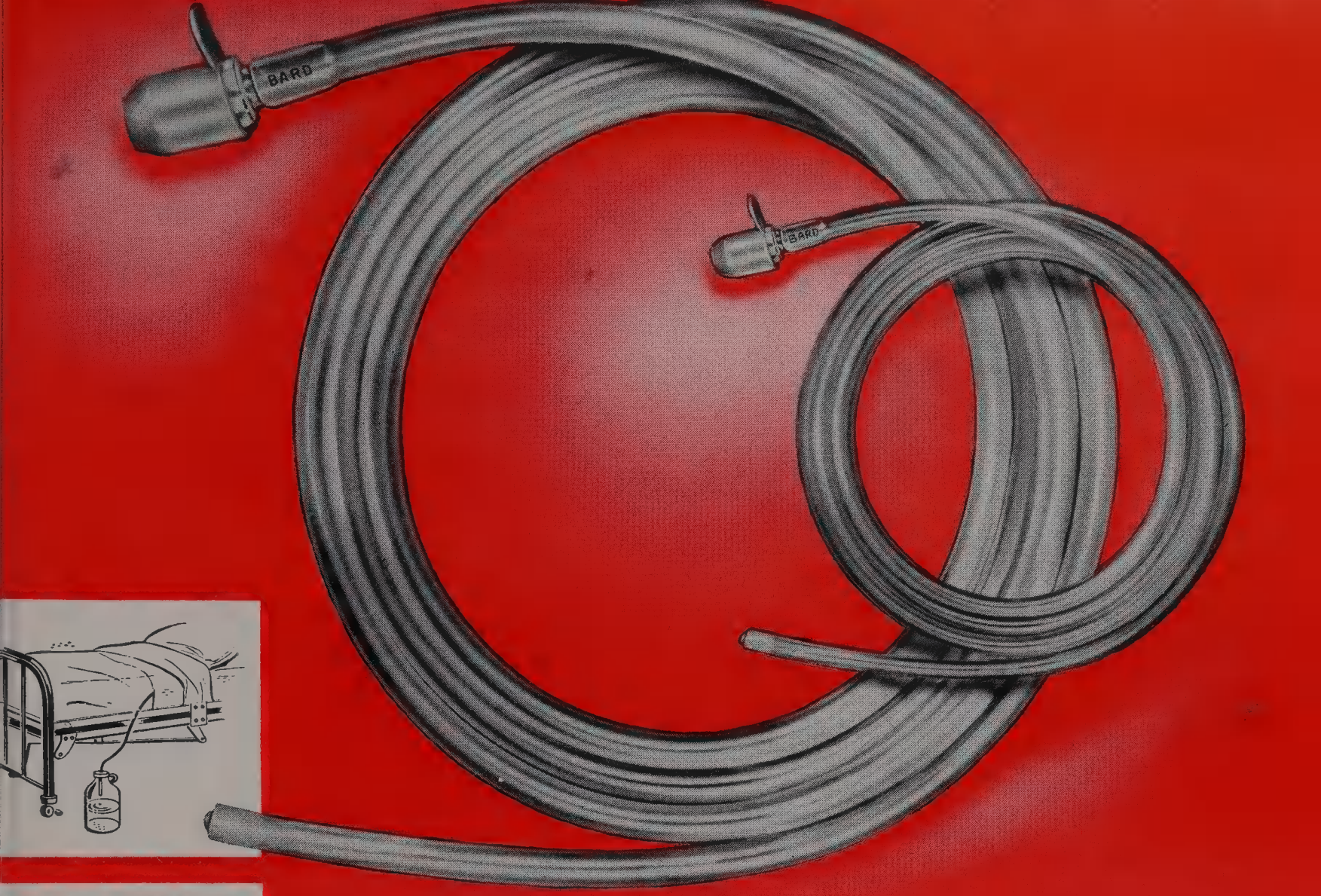

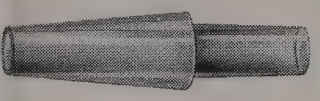

his new tapered adapter is asily inserted in catheter fun- el and provides a strong, on-slip connection.

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TIME SAVING • ECONOMICAL • EFFICIENT

STERILE PACKED—The Bardic Disposable Plastic Drainage Tube has a sterile fluid path and is packaged in an individual box ready for use.

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ACTUAL SIZE

1000R
3/16" lumen

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"There is No Satisfactory Substitute for Quality"

EDITOR TALK

HP's February Bonanza

■ With this section (Part One) of the February HOSPITAL PROGRESS you have also reecived Part Two, containing the Directory data which formerly appeared in March. We can assure our readers that it took prodigious effort by both the Editorial and Advertising Departments to thus advance the publication date by one month. We hope that the usefulness of this material will be enhanced by being in readers' hands so much earlier.

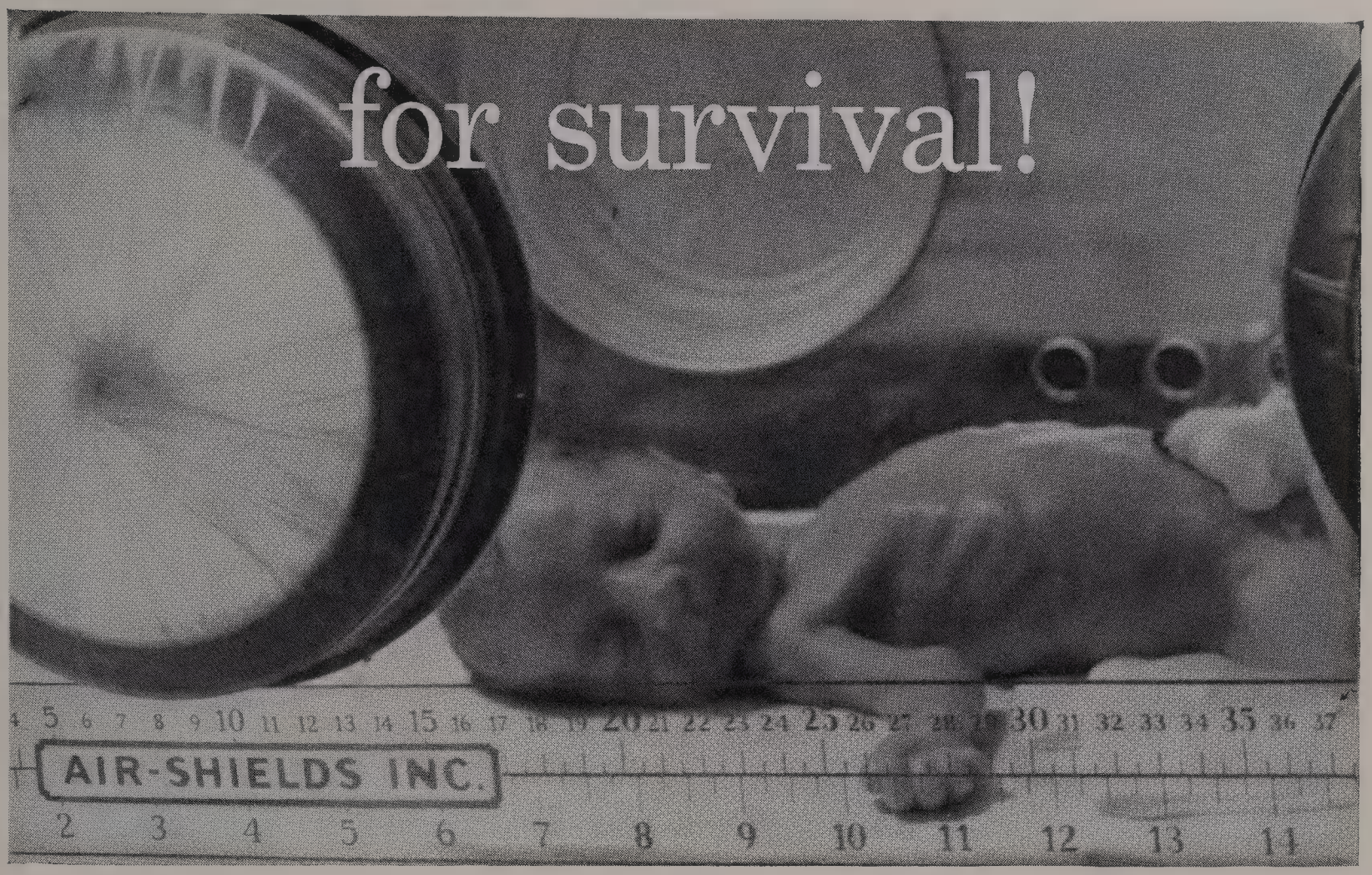
Since both Parts of the magazine must—by postal regulation—be mailed together, Part One has been kept slim to reduce the total mailing weight. The two sections combined, however, offer more editorial material than is found in an average monthly issue, so don't be misled by the size of Part One alone.

"Once-a-Year" Brotherhood?

■ A thought worth pondering not only during Brotherhood Week (which this year is February 19-26), but throughout the year is the following, uttered by Bishop Mark K. Carroll: "Common to all Christians and Jews and any creature created by God is the great Commandment of Love . . . True charity admits of no substitute. If we prostitute our love by admitting some and excluding others from our sections because they differ from us in race, color, political beliefs, then we are counterfeit religionists and traitorous Americans."

Spread Word of Bishops' Relief

■ We would like to say a few words here regarding the 1956 Appeal of the Catholic Bishops' Relief Fund. A nation-wide collection will be taken up on Laetare Sunday, March 11, in parish churches—or donations can be sent direct to the Fund's National Headquarters at 350 Fifth Avenue, New York 1, N.Y. For the tenth year, this praiseworthy endeavor is asking the co-operation of those able to give of their prayers and money. The Appeal asks, "Is there any act of yours that will pay such magnificent dividends as your investment in global charity?" The Fund's splendid record of past performances deserves hearty endorsement and aid.



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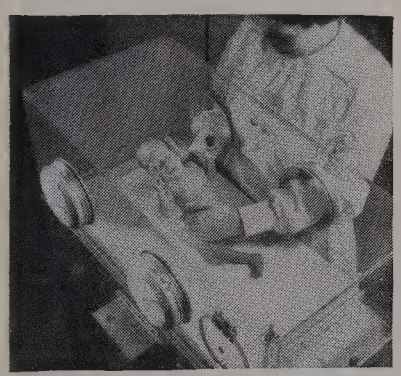
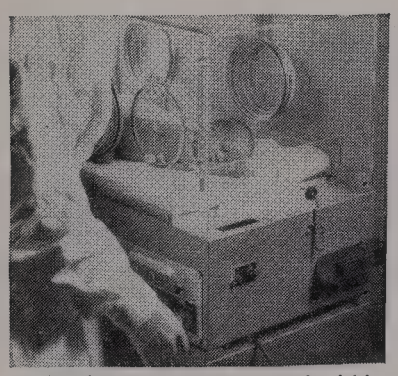
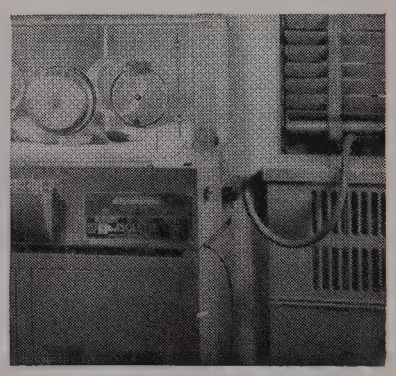


1. Controlled circulation of air: Maintains uniformity of humidity, warmth (and oxygen, if needed) to a degree impossible through convection alone. Isolette hood need never be opened.



2. Precise temperature control within a tolerance of 1°F . . . with provisions for cooling as well as heating, and automatic alarm should outside factors cause overheating.

3. Positive humidity control through a single setting of a simple control valve. Constant, controlled recirculation maintains relative humidity at optimal level, as high as 85% to 100%.



4. Complete isolation: The individually air-conditioned Isolette® uses fresh, outside air . . . protecting the infant from air-borne pathogens and droplet infection from the nursery.

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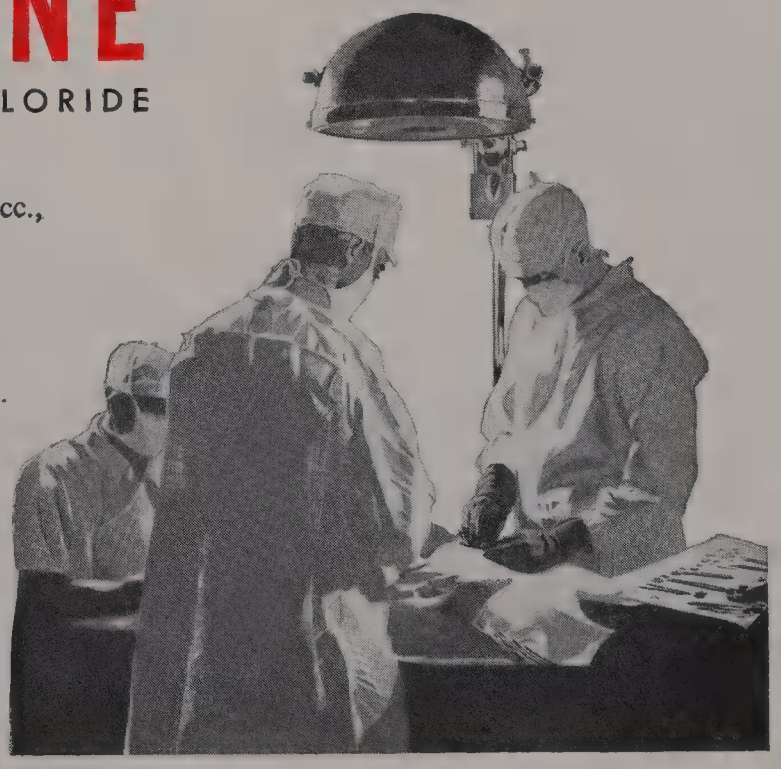

References:

1. Bonica, J. J.: *Anesthesiology*, 11:716, Nov., 1950.
2. Moore, D. C.: *J. A. M. A.*, 146:803, June 30, 1951.
3. Bonica, J. J.: *Anesth. & Analg.*, 30:76, Mar.-Apr., 1951.
4. Bonica, J.J.: The Management of Pain. Philadelphia, Lea & Febiger, 1953.
5. Moore, D.C.: Regional Block. Springfield, Ill., Charles C Thomas, 1953.

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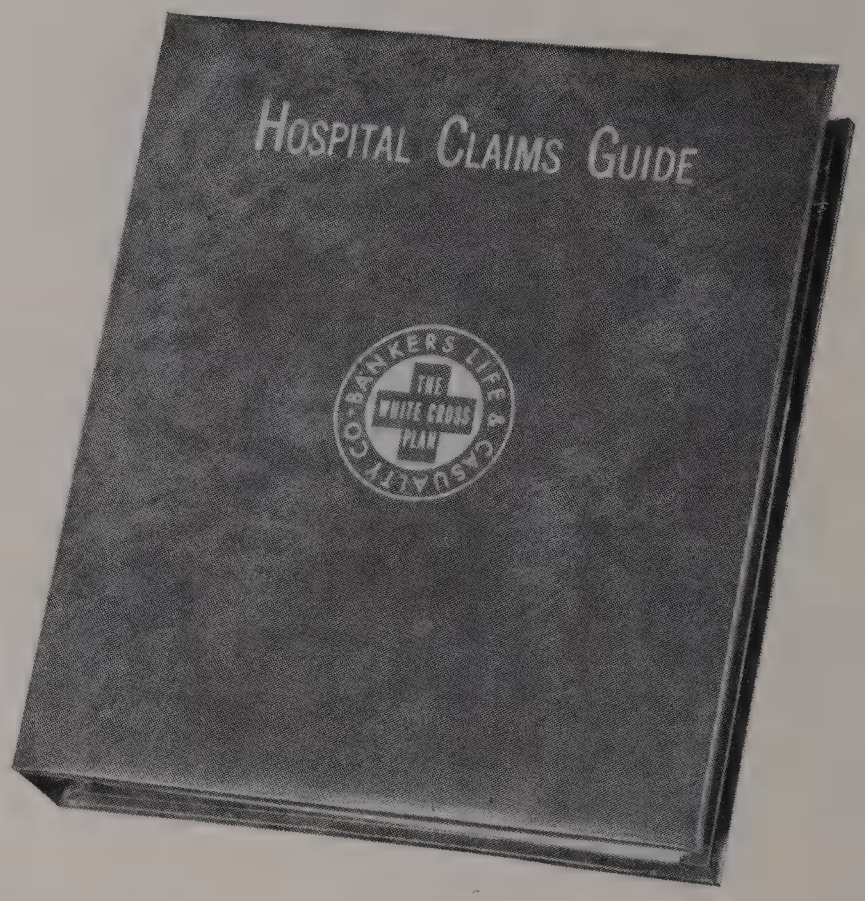

TO THE HOSPITAL ADMINISTRATOR:

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The Hospital Claims Guide has been furnished every hospital in the localities in which the BANKERS LIFE AND CASUALTY COMPANY is licensed. If, by any chance, you have not received your copy, please let us know immediately as one has been reserved for you. A letter to Hospital Relations Department, Bankers Life and Casualty Company, 4444 Lawrence Ave., Chicago 30, Ill., will put your copy in your hands without delay. The BANKERS LIFE AND CASUALTY COMPANY has developed this Guide for the use of your staff in the interests of advancing the high standard of efficiency maintained by all the hospitals of our country. They hope you will find it a useful tool in saving the time of your administrative staff; and in administering to the health and welfare of your community.

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HONEYWELL Bedside Temperature Control frees your nurses from "chambermaid chores" such as opening and closing windows, carrying blankets from the storeroom, refilling hot water bottles. It gives your patients fingertip adjustment of their own personal comfort.

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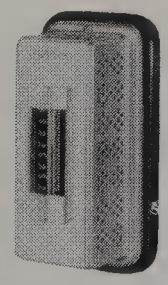
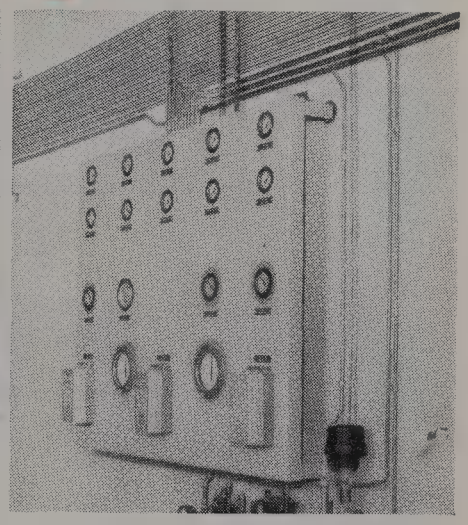


Mercy Hospital, Sacramento, Calif. Harry J. Devine, architect; Lester A. O'Meara, mechanical engineer; M. R. Carpenter, mechanical contractor; all of Sacramento.



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Successful, economical regulation of hospital temperatures and humidities calls for a control system that is capable of solving an exceptional variety of control problems. The Johnson-engineered Control System in the newly modernized and expanded Mercy Hospital in Sacramento, California, is an interesting case in point.

In the air conditioned surgery and nursery sections, Johnson Humidostats and Room Thermostats maintain correct humidities and temperatures by operating individual Mixing Dampers on the primary air supplied to each of 17 zones. A Johnson Room Thermostat and Humidostat in the emergency operating room control a separate air conditioning unit.

During the heating season, the heating effect of the building's existing steam radiators is automatically varied to compensate for changes in outdoor temperature.

Year 'round air conditioning for the new hospital wing is provided by centrally supplied room air conditioning units. Final room temperatures are controlled by Johnson Heating-Cooling Thermostats operating Water Valves on the heating and cooling coils in the units.

All of these, as well as many "behind the scenes" control problems, are successfully solved by Johnson to produce exactly the conditions desired for every purpose.

To insure maximum efficiency, the operation of all heating and cooling equipment is automatically coordinated. Output is limited to actual needs. Heating and cooling waste is eliminated. And the need for operating personnel and supervision is minimized.

Whether your particular temperature and humidity control problems involve a new hospital or an existing one, a single operating room or an entire building, a specially planned system of Johnson Control can provide equally satisfying results. An engineer from a nearby Johnson branch will gladly make recommendations without obligation. Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.

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TEMPERATURE ⇅ AIR CONDITIONING

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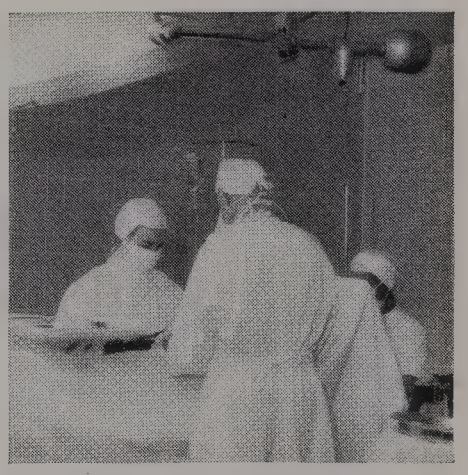
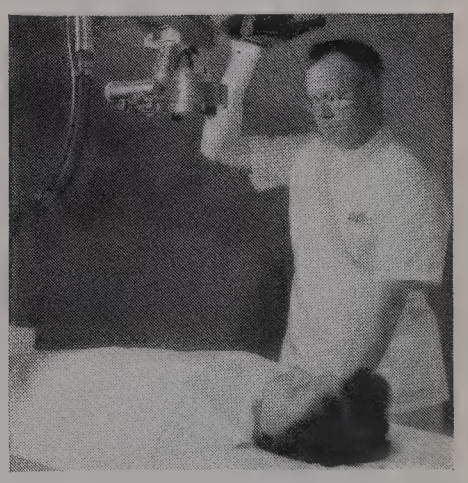
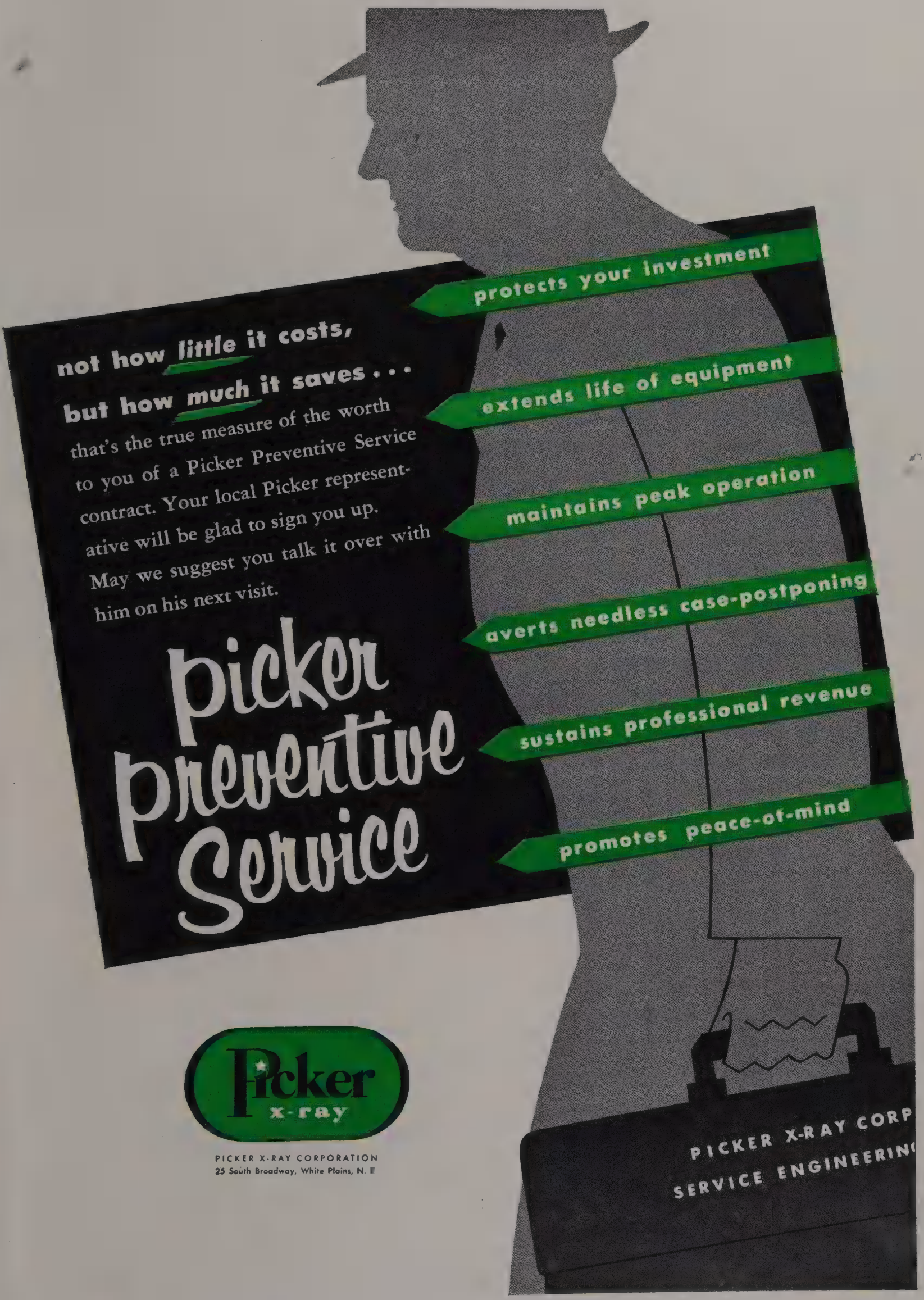


Pneumatically operated Johnson Thermostats and Humidostats safely control temperatures and humidities in vital areas.



Johnson Air Conditioning Control provides made-to-order "weather" in this and other rooms throughout the new wing.


not how little it costs,
but how much it saves . . .
that's the true measure of the worth to you of a Picker Preventive Service contract. Your local Picker representative will be glad to sign you up. May we suggest you talk it over with him on his next visit.
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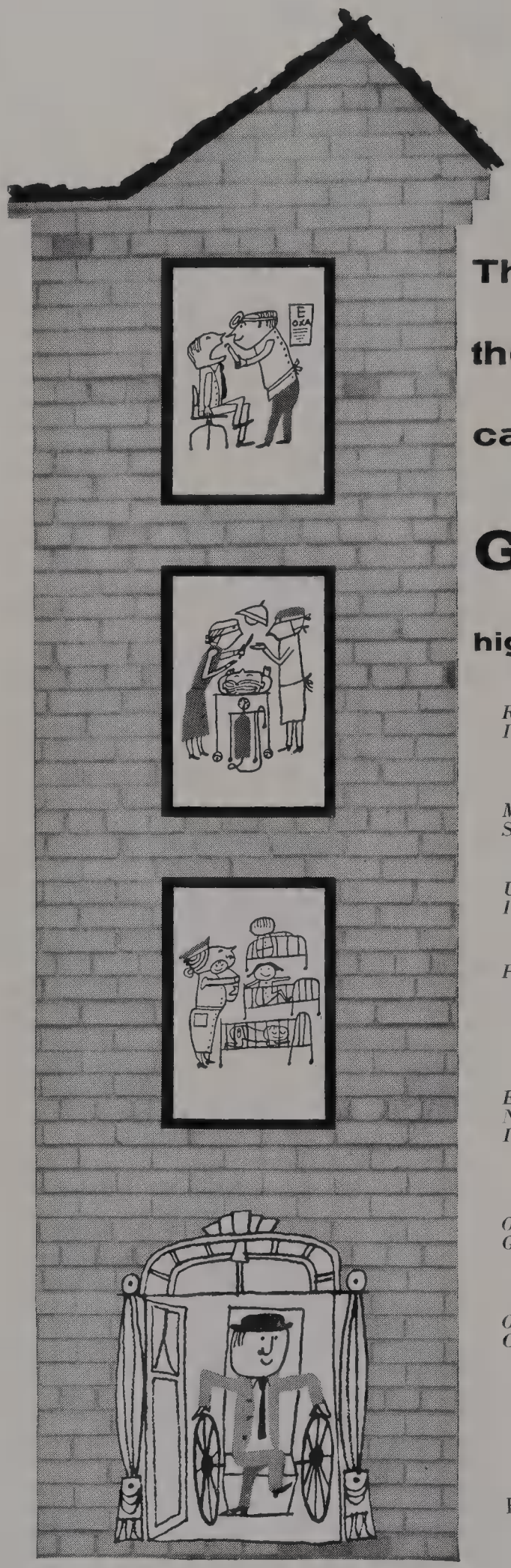

Throughout the hospital there are more and more calls for

GANTRISIN *'Roché'*

highly soluble, single sulfonamide

Respiratory Infections	tablets, 0.5 Gm each
Meningitis Surgery	ampuls, 5 cc (2 Gm) and 10 cc (4 Gm)
Urinary Infections	tablets, 0.5 Gm each
Pediatrics	pediatric suspension (raspberry-flavored), and syrup (chocolate-flavored), containing the new, tasteless Gantrisin (acetyl)
Eye, Ear, Nose & Throat Infections	ophthalmic solution, 4%, ophthalmic ointment, 4%, ear solution, 4%, and nasal solution, 4%
Obstetrics & Gynecology	vaginal cream, 10%, in white vanishing cream base
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Gantrisin®—brand of sulfisoxazole
Gantrisin® (acetyl)—brand of acetyl sulfisoxazole

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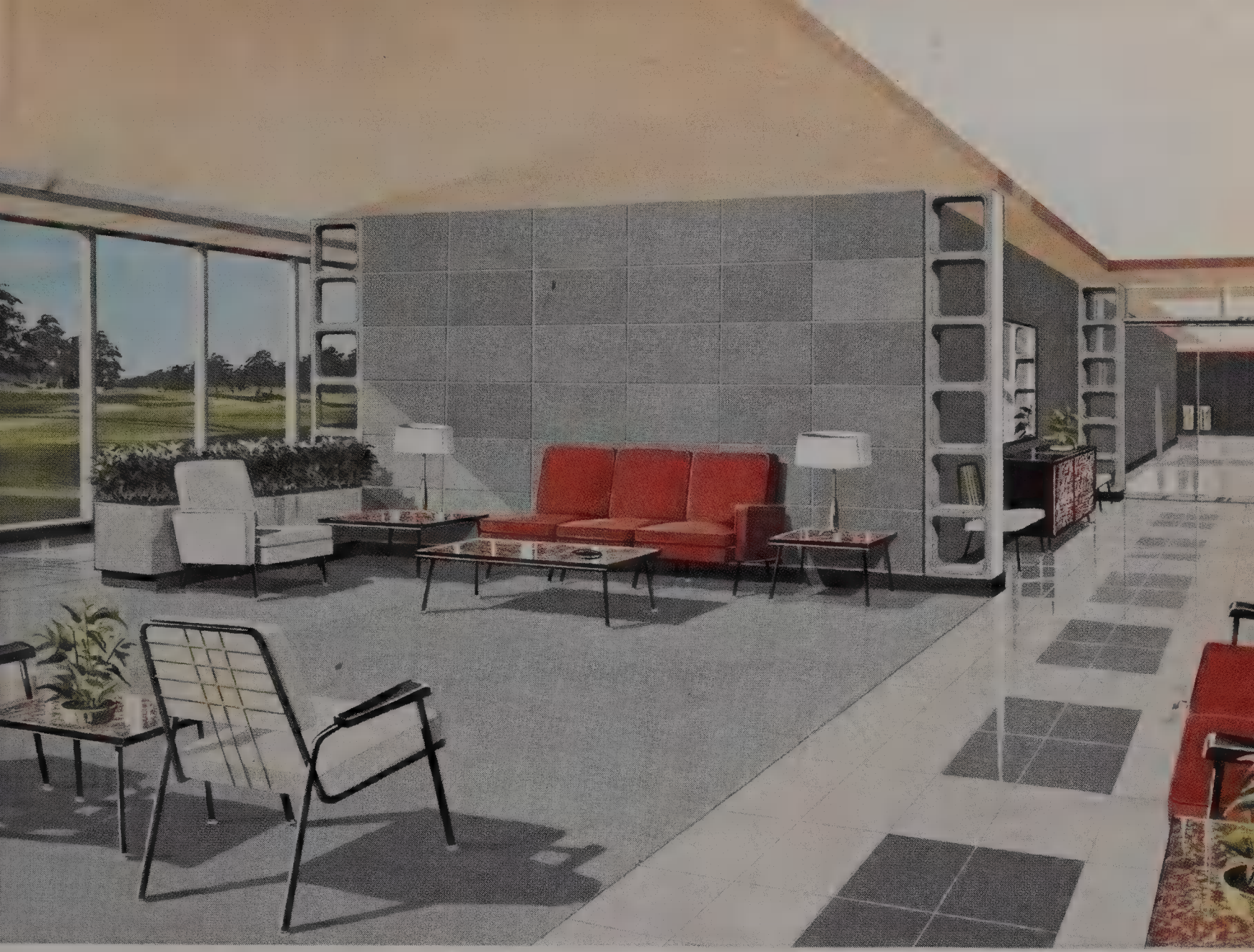

Theme furniture, by Simmons...

a theme that says *"Welcome"*

For hospitals, a friendly atmosphere...a setting both warm and gracious. *Theme* unit furniture, styled by the noted industrial designer, Mr. Raymond Spilman, was designed especially to meet the needs of those who serve the public.

Simmons built, this handsome line of metal furniture is safe, sturdy, can be cleaned and maintained with utmost ease. Fashioned in modular units, *Theme* furniture makes use of available space with amazing efficiency—permits an almost limitless variety of arrangements and combinations.

Selecting from the broad range of *Theme* units, Mr. Roy Johnson, A.I.D., has created the lobby illustrated above, using side chairs, Recov sectional units, easy chairs, settees, sliding panel chests and tables with decorative Textolite tops. These are but a few of the *Theme* pieces available.

For complete information, see the Simmons office or agent nearest you, or write to SIMMONS COMPANY, Contract Division, Chicago 54.

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no difference between protein hydrolysates?

Next time you're looking over amino acid solutions, check yourself on this question . . .

Why does one protein hydrolysate bring about more rapid recovery than another?

If protein hydrolysates differ in nutritive quality—and they do—the place to start looking is in the protein sources themselves. You'll need to know what amino acids are present—and in what proportion. (A variation in content of any one of the essential amino acids makes quite a difference, clinically.)

Of all the biologic proteins studied for nutritive quality, three—egg protein, lactalbumin, and fibrin—generally top the list. Of these, hydrolyzed fibrin is most suitable for intravenous use. From this, you might expect that a hydrolysate of beef blood fibrin (AMINOSOL®) would show superior nutritive qualities. Does it?

Cannon et al.[1] – in a 10-day feeding of protein-starved rats—found that AMINOSOL produced approximately 50% more weight gains than either an acid hydrolysate of casein or a beef plasma hydrolysate. Frost et al.[2] rank it considerably above casein hydrolysate for plasma regeneration and nitrogen repletion. Carroll[3] notes that AMINOSOL is "well tolerated and efficient when given intravenously . . . When studied by other workers, this product has proved to be of the highest nutritive value."

There are other considerations, of course. Sodium content, for instance, is extremely low in AMINOSOL—an important point when sodium must be held back. Also, potassium ion has been added to insure optimal tissue repletion. You can get AMINOSOL with or without dextrose and alcohol—and, of course, it's available with fructose for stress situations. Check into it. Chances are, AMINOSOL can fill a need for you. Abbott

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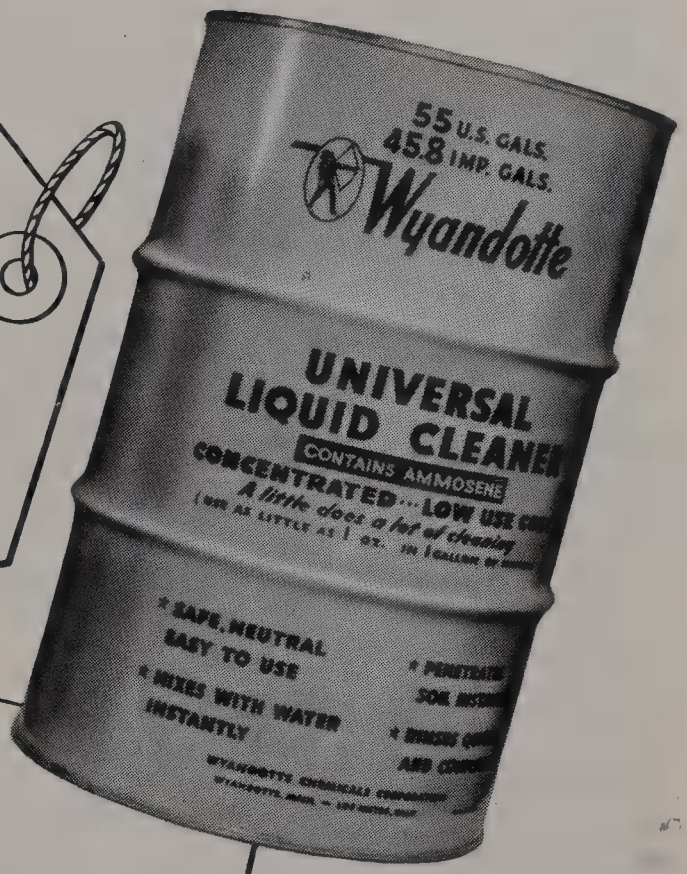
1. Cannon, P. R., Frazier, L. E., and Hughes, R. H. (1950), Protein Hydrolysates—Food for the Sick, Research Reviews, Office of Naval Research, November, p. 13. 2. Frost, D. V., Heinsen, J., and Olsen, R. T. (1946), Intravenous Use of High Levels of Fibrin and Casein Hydrolysates in Hypoproteinemic Dogs, Arch. Biochem., 10:215, June. 3. Carroll, W. W. (1954), Parenteral Fluids in Gastrointestinal Surgery, Surgical Clinics of No. America, Vol. 34, No. 1, Chicago Number, February.

Here's a NEW liquid cleaner for better floor care!



Big benefits cause rapidly growing customer demand for Wyandotte...

UNIVERSAL LIQUID CLEANER

There's nothing to compare with Wyandotte Universal Liquid Cleaner. Already—a short four months since it was introduced—it has received widespread customer acceptance.

Universal Liquid Cleaner cleans faster, with no skin irritation, no back-breaking effort. You get *depth cleaning*—thanks to amazing Ammosene . . . locked in chemically to give you better cleaning results.

Universal Liquid Cleaner is practically neutral—safe on all surfaces that water alone will not injure.

Universal Liquid Cleaner is full-bodied, concentrated—makes high, long-lasting suds . . . contains no soap. It is shipped to you in sealed containers, your guarantee of uniform concentration drum after drum.

If you prefer an effective, hard-working cleaner *in powder form* . . . try Wyandotte's F-100* for cleaning and dewaxing floors, washing walls and painted surfaces.

Call on your Wyandotte man for a demonstration of Universal Liquid Cleaner. While he's there, have him survey *all* your cleaning operations. He carries Wyandotte's *complete line* of specialized cleaning products—and his tips can save you money.

*REG. U.S. PAT. OFF.

Gives you all these benefits:

- **Neutral**
  —Safe on all washable surfaces
- **Greater cleaning power**
  —thanks to amazing Ammosene
- **Easy to use**
  —Cleans safely and thoroughly
- **Rinses easily**
  —Leaves no powdery deposits
- **Safe on hands**
  —Does not irritate the skin
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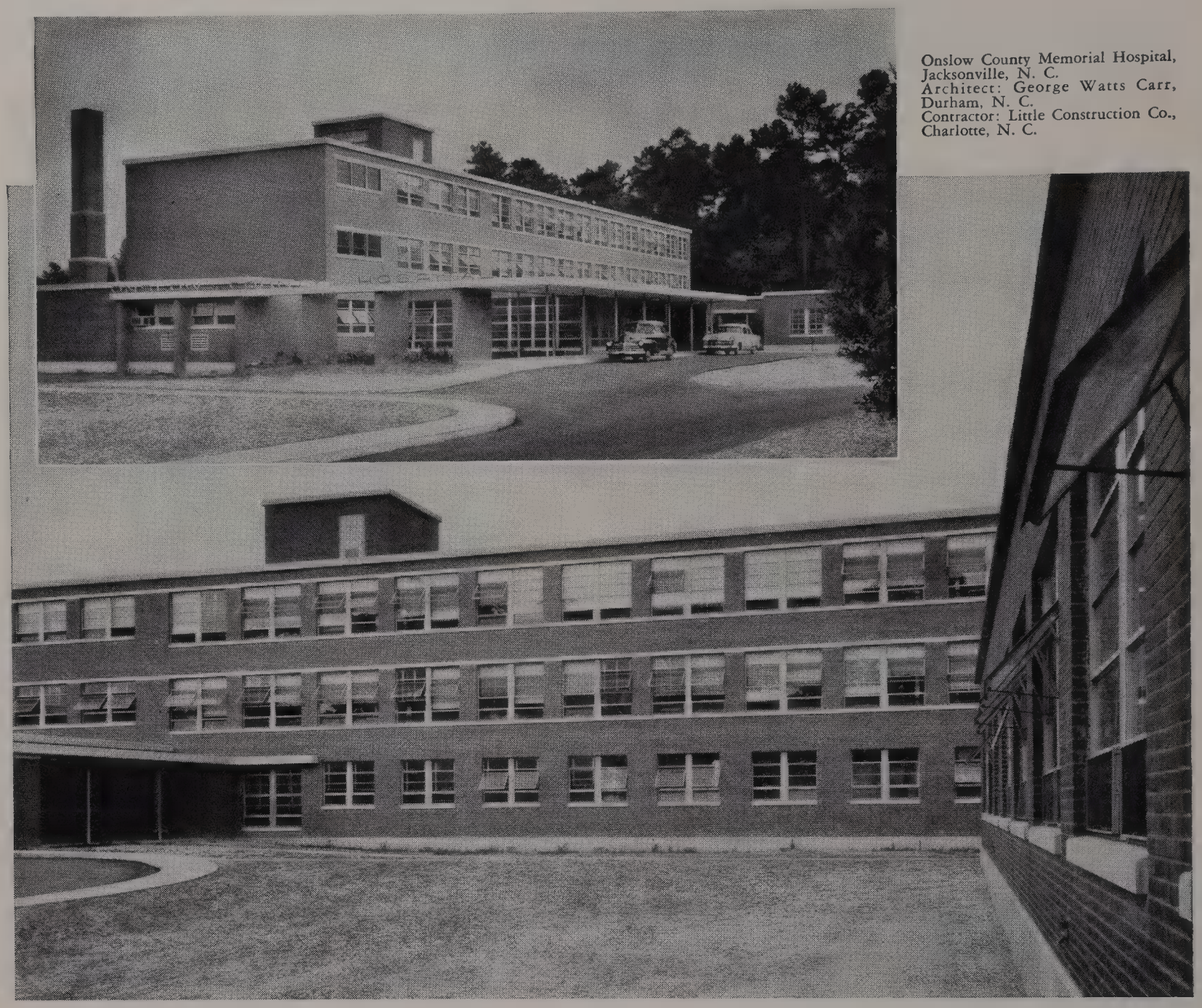

Onslow County Memorial Hospital, Jacksonville, N. C.
Architect: George Watts Carr, Durham, N. C.
Contractor: Little Construction Co., Charlotte, N. C.

Lupton Windows keep upkeep down

With its exterior of brick, stone and never-need-painting Lupton Aluminum Windows, this new hospital has no maintenance problem . . . a mighty important factor in today's expensive labor market.

But that's only one advantage of Lupton Metal Windows. Their precision manufacture, the direct result of fifty years' experience, helps assure windows that always work like "new" . . . that operate day after day with the ease they did when installed . . . that always keep their shape and close tight.

Available in steel or aluminum, in a wide range of types and sizes, architects have no trouble at all in selecting Lupton Windows that suit the style . . . and the budget . . . of any building.

and now . . . the modern LUPTON CURTAIN-WALL

Build the modern way, with the Lupton Simplified Curtain-Wall System. Walls and windows are prefabricated at the plant to speed erection on the site. Building construction is faster, more efficient.

Ask your architect to give you the complete Lupton story — Windows and/or Curtain-Walls — or write

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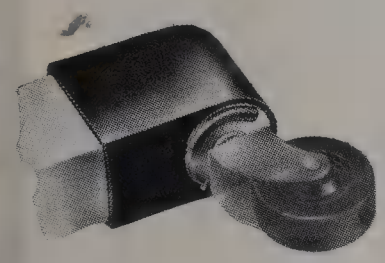
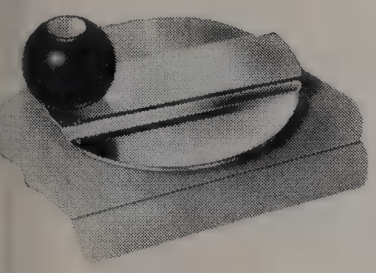
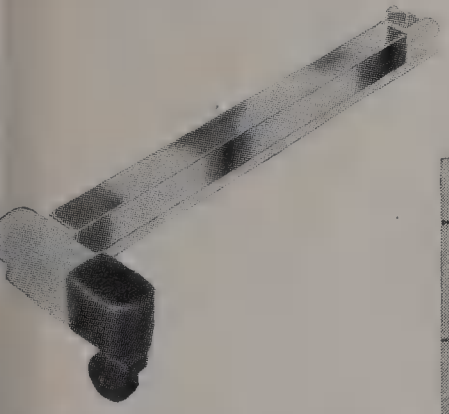
LUPTON **METAL WINDOWS AND CURTAIN-WALLS**



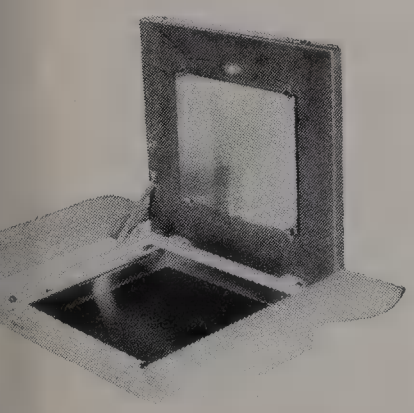
All four legs (walls and other furniture, too) protected by rubber bumpers like these. Notice that these bumpers are a built-in, intricate part of the table — cannot be lost.



Crank handle is on top of table for ease of operation, yet is designed so as not to snag attendant's clothing or the bedding.



Stainless steel scuff plate reduces maintenance costs by protecting finish from scuffing. (Optional)



Patients appreciate the easy, double-action of this center section which adjusts to three different angles on each side. Exclusive safety feature prevents mirror from accidentally falling or being knocked flat — an accident which might break the mirror or the patient's fingers.

NEW HARD ⑤ FEATURE OVERBED TABLE

Like every piece of Hard Hospital Furniture, this overbed table meets *all* five hospital requirements.

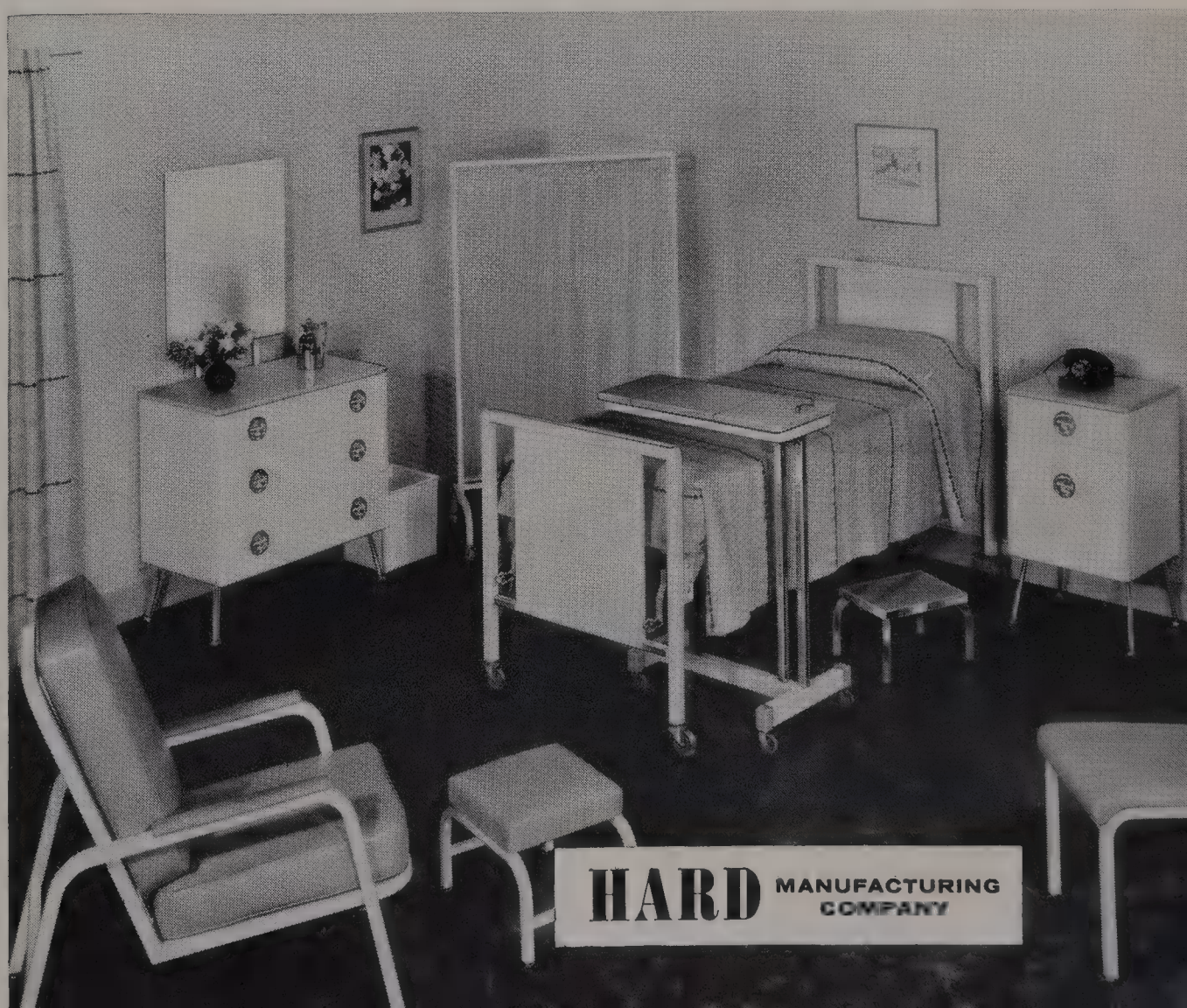
HARD ⑤ FEATURE HOSPITAL FURNITURE

Every piece of Hard hospital furniture is built around ⑤ specific features. ① **SAFETY** for both patients and attendants alike. ② **EFFICIENCY** — designed to do its job efficiently, including both ease of use by attendants and convenience and comfort of patients. ③ **EASE OF MAINTENANCE** — resulting from thoughtful design, sturdy construction, durable, chip-resistant finishes and intelligent use of scuff plates and bumpers. ④ **STYLING** — pace setting styles that make the Hard line the most attractive, most practical and most comfortable in the entire industry. ⑤ **GUARANTEE** — Hard's 75 years of experience plus its reputation for top quality is your best guarantee of hospital furniture.

Every piece of Hard ⑤ Feature Hospital Furniture has been designed with the help of the Hard Panel of Hospital Experts. This panel made up of administrators, doctors and nurses carefully check every Hard design and every new Hard product. Panel approval assures you that every piece of Hard hospital furniture meets *every* hospital requirement. When you equip with Hard hospital furniture, you follow the lead of outstanding hospitals the country over.

HARD MANUFACTURING COMPANY
BUFFALO 7, NEW YORK

Shown below is Hard's ⑤ Feature Omega Room Group



★

Blue Cross Is Due Congratulations

THE BLUE CROSS COMMISSION of the American Hospital Association recently announced that more than 50,000,000 members now belong to the 86 Approved Blue Cross Plans of the United States, Canada, and Puerto Rico.

This membership is indeed an achievement for an organization just celebrating its 25th anniversary.

But the record of Blue Cross contributions both to this community and to the nation as a whole fully explains the phenomenal following that is Blue Cross's.

The record is outstanding. Hospitals will have been paid an estimated $885,000,000 during 1955 for the care of nearly 8,000,000 Blue Cross members.

We congratulate Blue Cross on its membership, its principles and its success in providing hospital services to the nation through its method of prepayment.

★

Attitudes Toward Older Employees Are Shortsighted

ONE OF THE MOST HEARTLESS POLICIES in the business world has been the indifference of employees to the needs and the abilities of men and women who have passed middle age. In their zeal to staff their organizations with young men and women, business leaders have overlooked their obligations to men and women who have served faithfully and given of themselves generously. After years of faithful and generous service, at a time when family obligations may be heavy, at a time when they might expect to receive respect because of their experience, they are often discarded in favor of younger people. Men and women barely beyond their prime find it difficult to change positions or to obtain new positions when unemployed.

Such an attitude towards these older men and women is not only unchristian and harsh—it is also shortsighted. There is no substitute for experience. It takes years to develop sound judgment and the depth of knowledge needed for positions of responsibility. It is a very narrow point of view and inefficient use of talent and experience that relegates our older people to the "has-been" category.

It is unfortunate that some hospital administrators and supervisors have been influenced by this short-sighted, unchristian attitude. Despite the great need for well-trained nurses and technicians in hospitals, the older nurse and the older technician do not receive the welcome they deserve.

Perhaps we are missing an opportunity in not exploring more fully the personnel available to us in the older age groups. Many men and women who have reached retirement age in business can bring valuable management experience to our institutions.* Certainly older hospital employees should be valued because of their special knowledge.

These days, when so much time and money are expended in preparation for a career, it seems sinfully wasteful not to utilize to the fullest any available assets of education and experience. Youth is wonderful!—and it is true that we need youth and young ideas. But youth needs the guidance, the experience and the tolerance which only years can bring. Hospitals need young people, but they also and commensurately need older and experienced heads for balance, stability and perspective. ★

*Cf. the article, "Stop Shelving Senior Citizens Too Soon" in the January, 1956 issue of HOSPITAL PROGRESS.

The Purchasing Agent's Relation to Operating Departments

by **MARK BERKE**
Director
Mount Zion Hospital
San Francisco
Calif.

ALTHOUGH MUCH HAS BEEN SAID about the role of the purchasing agent in hospitals, we find that in many of them he is not a purchasing agent at all but an "order placer," harassed by dissatisfied personnel who look to him for service, but who do not get it. He is disorganized, he has no real system that everybody understands and follows, and he rarely leaves his office to get into the areas where the items he purchases are actually being consumed. He is a one-man department who acts with the authority of a feudal lord. He bears little or no resemblance to his counterpart in industry, largely because his place in the organizational pattern of the hospital has not been clearly established.

In all complex situations, specialization is an evolutionary characteristic that develops rapidly. We see it in industry where, for example, a new specialty of management engineering has developed in an attempt to plan for an efficient work-flow that results in greater productivity per employee. To bring it a little closer to our own environment, we see it in medicine with its multiplicity of specialty boards. We see it in the hospital, where the ever-increasing activity in all departments has created the need for the correlation and co-ordination of the purchasing and control of supplies. As the significance of purchasing increases, so does the delegation of authority by the administrator to the purchasing agent; and in these circumstances, the purchasing agent should not be regarded as a high-class clerk, or on the level of a buyer in a department store, but instead as an executive, an integral part of the administrative team of the hospital.

It is generally accepted that the purchasing agent's position is an advisory one, and that his policies are established in consultation with, and by the approval of, the administration of the hospital. The purchasing agent is responsible for the purchasing of materials and supplies for all departments —with certain exceptions in some hospitals, notably in food and drugs— and it is his responsibility to insure that the hospital's dollar is spent economically and wisely. In short, a good purchasing agent can "make" a hospital, and a poor one can break it.

That is the accepted, or textbook, version of the functions of a purchasing agent. In reality, the story is not quite so cut-and-dried. Too often, the purchasing agent attempts to dictate to a department head what materials that department should use; almost invariably—and naturally—friction results. The nursing director complains that unless she gets the quality of syringes that she wants, the waste will be enormous, and asks how she can be held responsible for running her department economically and well under such circumstances. Undoubtedly there *will* be great waste if the syringes are not the type she wants. She will make sure of that.

In defense of the dictatorial purchasing agent, we must admit that he is frequently forced into an unfair position by his administrator. It seems to be quite common for an administrator to discuss the function of the purchasing agent at a department head meeting and to tell the group that the purchasing agent is to be advisory to them and that nothing will be bought against the department's wishes; and then to have a private chat with the purchasing agent and to say: "Now remember, don't let them get away with anything! You're in charge— you buy what you think is right. All our people have fancy ideas, so it's up

Is it true that, as the author says, " . . . A good purchasing agent can 'make' a hospital and a poor one can break it"? Mr. Berke develops not only principles but exceedingly practical applications of them in the article on these pages.

to you now to keep our costs down."

On the other hand, there are purchasing agents who conceive it their duty to buy what they think best regardless of the wishes of the department head. As far as they are concerned, nobody else knows anything —at least, not in the field of buying materials and supplies.

Before anything constructive can be done, it is essential that the administrator tell his department heads honestly what he conceives the function of the purchasing head to be, and that there be no secret covenants with his purchasing agent which are contrary to what the department heads have been told. Having obtained that happy, if unusual, state of affairs, a well-functioning relationship between the purchasing agent and the operating department heads may develop.

Service to Individuals

It is important to note that the purchasing department is a service department. It is a department that exists to provide service to individuals—not directly to the hospital as a whole, for it is difficult to serve bricks and mortar—but to the individuals who are the hospital. Those individuals are personnel, doctors, patients and anybody else with an interest in the institution.

How does one serve these individuals? Not by believing one knows more about sutures than the operating room supervisor (because no purchasing agent will ever know as much about catgut as the O.R. supervisor does—unless he formerly was an O.R. supervisor), but by keeping his O.R. supervisor posted with the latest data on the result of tests, of new materials, and of the market generally, since he has more time to study these matters than she has. In this way, the department head can be guided by the purchasing department, and hopefully, will learn to trust the judgment and integrity of the purchasing agent.

This is of particular importance, because good relationships must be established on mutual faith and trust. Here is where we enter the area of human relationships, and it is at this point that we must begin thinking about the working relationship with department heads.

It must be recognized that to talk about this "working relationship" is an over-simplication, since a purchasing agent has many relationships with his department heads, both on an individual and a group basis. He will, for instance, have one relationship with the group when he first meets them; another after he has been with them for a year; another when he is with them at a group meeting; another when he is with them at the annual hospital picnic, and so on *ad infinitum.* In addition, there are as many different personal relationships as there are department heads. With some he will be socially friendly, and with others he will have only "business" contacts.

"In any case if the relationship between the purchasing agent and the other department heads is to be sound, of mutual benefit, and one that makes a contribution to the efficiency of the hospital, the purchasing agent must spend more than a little time thinking about how people are motivated."

In any case, if the relationship between the purchasing agent and the other department heads is to be sound, of mutual benefit, and one that makes a contribution to the efficiency of the hospital, the purchasing agent must spend more than a little time thinking about how people are motivated. Without some understanding of this, it is difficult to work consciously toward developing any sort of relationship with either an individual or a group, and the result may well be an appalling waste of energy, a loss of enthusiasm and an increase in frustration.

Obviously, the maintenance of an effective organization is a complex and delicate process in which each person must deal with his peers and co-workers both as individuals and as parts of the whole system. All department heads must consciously, conscientiously and constantly plan their individual human relations programs as thoughtfully as they do their laundry production, their storeroom control or their nursing service. It follows that the purchasing agent must arrange matters in such a way that each department head will identify with him, will want his work to be successful, will feel free to co-operate with him, and will want to make the necessary effort to maintain that co-operation.

This result cannot be obtained through a system. It is obtained through an attempt to understand human behavior, individual adjustment and social organization.

This both sounds and is difficult, but human relationships constitute one of the most complex subjects that can possibly face us; nevertheless, the goal is not so far out of reach that it requires years of formal study. If it did, few would be successful in the field of administration. It would seem that it can be learned on the job, and that most successful hospital administrators and department heads have mastered the art, perhaps without a conscious realization of the fact. But it does have to be worked at, and some of the principles involved should be discussed.

Human Relationship Factors

1. *Every organization has both a formal organization pattern and an informal one.*

The informal one, which is at least as important as the formal one, results from such things as friendship, cliques, and similar spontaneous relationships. It is the custom to decry the informal organization, but it is impossible to eliminate, and one should try to adapt it for useful purposes if for no other reason than the fact that the grapevine is almost always a more efficient means of broadcasting information than are the more formal and established channels of communication.* One wishes it were possible to control the accuracy of the information thus disseminated.

2. *Every organization has a high degree of inter-relationships between its parts.*

Since change at one point of the system has wide-spread results, information on any such change must be widely disseminated.

One hospital decided that to establish a good system of obtaining bids

*An illustration of how the grapevine can be used successfully was the case of the hospital whose accountant refused to submit his requisitions at the correct time. The purchasing agent let it be known to some people in the cashier's office that the accountant's was the only department that was a problem in that regard—and it worked like a charm. Within a week the purchasing agent was congratulating the accountant on his increased efficiency, the accountant was congratulating the purchasing agent on his excellent distribution system, and the administrator was congratulating everybody and himself on the success of his re-organization program.

and quotations, all purchase requisitions would have to be in the purchasing office by noon Thursday, so that the bid lists could be typed by Friday and be in the mail by Saturday. Anything not received by noon Thursday would be held until the following Thursday. Until this system came into being, requests for bids had been mailed almost every day. The new system was indeed helpful and saved a great deal of time, but it had not been in existence for two weeks when the chief of medicine came storming down, denouncing the red tape that had held up the delivery of his badly-needed pressure cuffs.

3. *An organization, like any other organism, resists change.*

An attempt to change a procedure, therefore, will invariably meet resistance somewhere, and after the resistance has been overcome, a certain period of readjustment will be needed to bring the system back into balance. Thus, when a purchasing agent decides that (1) he is tired of seeing requisitions every day, and (2) he will no longer require the nursing department to do paper work for their floor supplies but that (3) instead, with the co-operation of the nurses, he will set up floor standards, and that (4) he will automatically fill the standards each week (thereby saving the nursing personnel a great deal of clerical work), he may not get any thanks for the change. Many nurses will resist the new method until they get used to it, although they will then often sneer at the time-consuming methods used in other hospitals.

4. *Every organization has a "status" pattern.*

As a result, some rank higher and some lower, and everybody is aware of his place in that pattern. If the purchasing agent indicates in front of a laboratory technician that the laundry manager who wants to change the soap used in the laundry does not know what he is talking about, it will be rather difficult to establish good working relations with the laundry manager thereafter.

On the other hand, while it is flattering to credit somebody lower down in the heirarchy with more status than he or she actually has, it can also be dangerous. It is good for the nursing supervisor's ego to be asked for advice about the use of certain equipment, but if she is so flattered that she talks about it, the purchasing agent may have an irate director of nursing accusing him of ruining her organization.

5. *Through education and development, the individual has developed certain concepts as to what he wants and what he expects.*

Sometimes, in spite of the need for economy and efficiency, it may be well to cater to such concepts.

In one hospital there was a chief of surgery who insisted on using only the instruments of a certain manufacturer. When the purchasing agent learned that the same instrument, made by the same manufacturer, was being sold by a hospital supply house under a different name and at a lower price, he endeavored to get the surgeon to agree to accept the lower-priced instruments. The surgeon refused to change, and finally the purchasing agent abandoned his attempts, without taking the problem to the administrator. The purchasing agent's reasoning was sound, for he believed that if the surgeon actually felt more confident while working with the costlier instruments, he should be permitted to use them for the patient's benefit.

One measure of the successful human relationships is the ability to get department heads to work with the purchasing agent. The logical approach is through the person's intellect, but often it happens that the department heads will not listen; or, if they listen, they are not convinced; or, if they are convinced, they do nothing about it anyway. They have accepted the situation intellectually, but not emotionally. These people must have their emotions appealed to, and in such situations logic is of little use. It is worth discussing four of the specific problems (there are, of course, many others) which can arise and in which a logical approach may be useless.

1. *The new purchasing agent.* A new man entering this job often encounters a certain reserve or "standoffishness" from the other department heads. The reasons for this may vary. In part, it is probably natural, as a certain aloofness is common among strangers. Perhaps the former purchasing agent, if there was one, was held in great esteem, or perhaps there is an "old guard" who themselves feel threatened by the change in the purchasing office. Perhaps the purchasing agent's job is a new one in the organization, and each person fears she is going to lose some authority in the new set-up.

In any situation of this type, the new purchasing agent must take a lack of warmth for granted. If he remains natural and is fair to all; if he refrains from criticizing his predecessor and is not too hasty about making changes; and if he remembers that friendships must mature and be based on mutual understanding, then time is on his side and the situation will probably work itself out.

2. *Opposition.* Sometimes the purchasing agent will find himself faced with a deep-seated opposition from his associates. A department head may deliberately make it difficult for him to do his work, or may purposely magnify his errors or spread criticism in an attempt to undermine his position.

Perhaps the best thing to do in these circumstances is to ignore the situation unless it affects the work of the department. If this happens, then the purchasing agent must take a mental step backward in an attempt to look at the problem objectively. What, if anything, has he done to bring about such a problem? What is there in his approach to this department head that is wrong? Can the situation be improved through frank discussion, or through informal channels?

If the purchasing agent is really satisfied that the fault is not his, and that he cannot rectify the situation, then in self-defense he must go to his administrator and inform him of the problem —but he had better be unemotional and judicious in his story, or his administrator will wonder where the fault really lies.

3. *Politics.* Few organizations are free of politics, and certainly few hospitals are free of it. In this case, the purchasing agent can be presented with some unequivocal advice and that is: "Steer clear." He who lives by politics will be fired by politics—which is sound advice for the administrator, also.

4. *Responsibility for errors.* In the best run departments, a clerk or storekeeper will make errors which will result in criticism from other departments. Any consistent attempt to avoid such criticism by blaming it on the employee will speedily result in the purchasing agent's being held in contempt by those who have to listen to his excuses. It is axiomatic

(Concluded on page 62)

At right, an intern impersonates a patient as the technician sits at the somewhat intricate control panel of the plethysmograph at Mercy Hospital in San Diego, California.

VASCULAR CENTER'S PLETHYSMOGRAPH ADVANCES PERIPHERAL DIAGNOSIS

by EILEEN O'CONNOR • Mercy Hospital, San Diego, Calif.

A CATHOLIC HOSPITAL on the West Coast has been singularly honored with the acquisition of an instrument that allegedly establishes a "world first" in the march of medical progress.

The hospital so distinguished is Mercy Hospital in San Diego, Calif., where a Vascular Test Center has just been established. This Center houses the first plethysmograph in the world to measure accurately—and record—pulse beats, blood flow, blood pressure and temperature simultaneously. The instrument is the development of a Los Angeles internist, Dr. Travis Winsor of Good Samaritan Hospital.

The device is the most advanced known for the diagnosis of peripheral vascular disease. The instruments in the center at Mercy Hospital include recording plethysmograph, recording thermistor, recording oscillometer and a recording sphygmomanometer. (In plain English "plethysmograph" means "pulse tracer"—an electronic device that pinpoints the cause of ailments involving the circulatory system.)

The "pulse tracer," which locates the exact spot in an artery where circulation is impeded, is an invaluable aid to the physician and surgeon in treating circulatory stoppages and slowdowns. It actually measures the throb of a pulse beat at a particular point on the body. The instrument will measure a change of displacement of as little as one-half cubic millimeter. That is approximately seven one-hundred-thousandths of a cubic inch.

The plethysmograph reveals where the artery is blocked, by the simple expedient of measuring the pulse at various points. It is so delicately adjusted that it not only enables the doctor to estimate the location of circulatory damage, but also the amount. By revealing the exact point of stoppage the machine shows whether or not the ailment can be treated by surgery. If surgery is indicated, it shows the surgeon exactly where to operate. One of its greatest benefits is expected to be in cases of artery grafts.

The "pulse tracer" all but speaks as it furnishes its answers by giving the doctor information on the differences in pulse records at different points at the same time. For instance, if the patient's legs show a weak pulse and the arms a strong one, the implication is that the block is in the aorta, the great artery that provides aerated blood to the lower body and legs. By moving the test points closer together, the "pulse tracer" can narrow the trouble zone down to a few inches.

The pneumatic principle on which the instrument operates is not new, since pulse surges have been measured by displacements for many years, but before the advent of artery banks and effective drugs, when there was little to relieve arteriosclerosis, it was useless to pinpoint faulty circulation.

The plethysmograph at Mercy Hospital was installed through the efforts of the San Diego Heart Association. The Test Center is available to both private and charity patients. The hospital is conducted by the Sisters of Mercy whose Mother House is in Burlingame, Calif. ★

PART I

Electrostatic explosion control in hospital operating rooms

by ROBIN BEACH*

SYNOPSIS

SPARKS originating from accumulations of static electricity on persons or equipment in hospital operating rooms sometimes ignite flammable mixtures of anesthesia vapor and air or oxygen, thereby causing injuries and fatalities by explosions.

The NFPA Committee on Hospital Operating Rooms in its Bulletin No. 56 on Recommended Safe Practice for Hospital Operating Rooms wisely specifies the use of flooring of moderate electrical conductivity throughout all hazardous areas. This provides a means of intercoupling all floor-borne facilities and individuals for the purpose of eliminating electrostatic sparks by equalizing differences of electrical potential.

The NFPA Committee recommends the resistance range of flooring between the limits of 25,000 ohms and 1 megohm, as measured by a 500-volt ohmmeter between two 3-foot spaced 5-lb electrodes whose bearing surface of 5-sq. in. each is provided with a soft rubber disk between the electrode and a contacting thin metal foil against the floor. The lower resistance limit provides neither safety to personnel from electrical shocks nor elimination of arc ignition of flammable mixtures, either or both of which may occur from faulted 125-volt electric cords or appliances.

This paper proposes 250,000 ohms for the safe lower limit of resistance and 10 megohms for the safe upper limit of resistance, suggesting a desirable median resistance for floors approximating 0.5 megohm.

The electrodes recommended by NFPA for measuring floor resistance introduce high contact resistance, thereby causing large errors of measurement. The paper suggests the use of thick conductive paste on the contacting faces of the electrodes whereby such errors of measurement are minimized.

With moderately conductive flooring within the proposed safe limits of resistance, no need is indicated for the installation of special transformer equipment and controls, as recommended by NFPA, to provide an insulated electric power distribution system throughout hazardous areas which, even as for grounded distribution service, also is subject to possible failure.

The high contact resistances which commonly exist between the flooring and conductive rubber casters and leg tips of floor-borne equipment thwart the safety sought through the desired floor intercoupling agency. Drag chains attached to portable equipment, which are commonly used for the alleged purpose of reducing these high contact resistances, fail to resolve this problem while, on the other hand, drag chains are notorious for creating their own peculiar brand of ignition hazards.

With all these effective physical facilities provided in operating rooms to yield safe conditions in controlling static electricity, the paper then emphasizes that the human element still gives rise to explosion hazards through failures in recognizing and applying safe procedures and techniques in service.

The long-discarded "pick-up" way of acquiring education, currently practiced throughout hospitals in the technology of safety, is deplorably inadequate, as it always is, in achieving any realistic degree of success. In place of this out-moded way of learning, modern concepts and approved techniques which are used in up-to-date methods of education and training are emphasized for properly instructing operating teams in hospitals so that they may achieve safe practices and learn to eliminate currently hazardous situations when they occur.

Objectives of Paper

Static electricity as generated in hospital operating rooms is, indeed, of no different parentage than that which haunts industry and, by its sabotage, causes costly and devastating fires and explosions. However, in hospital operating rooms, more causes for electrification occur within comparatively small areas than in almost any industrial plants. Also more hazards of potential explosion exist here than in many types of industry.

Because of the administration of pure oxygen mixtures rather than air with anesthetic products through rebreathing systems to anesthestized patients, explosive ranges are greatly broadened and explosions, when they occur, are intensified in the relatively small operating

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rooms. When explosions take place, generally at least one life is sacrified—that of the patient—and, sometimes, several injuries and destruction of physical plant result.

How, why, and where these electrostatic properties display themselves in hospital operating rooms, the philosophy of physical means for controlling the hazards, and the encouragement of education and training for the personnel to acquire knowledge and habits regarding safe practices in their duties, all are the objectives of this paper.

How Electrostatic Sparks Are Created

Static electricity is brought into being by the contact of one substance with another. This process by which electrification of the two substances is created at their contacting interface is known as "contact electrification." When in contact, unbalanced interatomic forces across the interface cause electrons to migrate from the substance of higher dielectric constant through the myriad of intervening contacting points to the substance of lower dielectric constant. This phenomenon occurs between all pairs of contacting substances whether they possess conductive or dielectric properties.[1]

The substance receiving the electrons thus acquires an electrification of negative polarity while the substance whence the electrons migrate possess an equal electrification but of positive polarity.

The differences of potential across interfacial boundaries which are attained for pairs of contacting substances, in rare instances only, reach a maximum of one volt; mostly, the voltage thus developed acquires an order of millivolts and, commonly, even of microvolts.

When two contacting substances which are being separated are conductors, all free electrons on the one surface at the interface return from whence they came before the last point of contact is broken. Hence, the conductors retain no electrification.

For insulators, the electrons which are acquired by the one surface in contact with the other are so effectively impounded by their lack of migratory freedom that they are quite effectively entrapped during the process of separation. Hence, if one or both of the substances are excellent insulators, following their separation they each are electrified and each displays the characteristics of respective positive or negative electrification.

Since no substances are perfect insulators, hence the speed with which the contacting substances become separated comprises a determining factor in how many electrons are entrapped; and, quite generally, the electrification attained from rapid separation of the two substances is materially increased. Within certain limits, the electrification of a substance during separation from another substance increases in linear proportion with the increasing speed of their separation.

The electrified surfaces of two substances in so-called contact comprise a capacitor and these surfaces, on either side of the interface, always possess opposite polarities.

As the two electrified surfaces at the interface are separated and assuming the electrification to remain at constant magnitude, the voltage between the surfaces increases directly with the distance of separation. In this manner, potential differences of thousands, tens of thousands, or even hundreds of thousands of volts may be developed between the separating surfaces.

Were it not for the two mitigating factors of charge conduction leakage and ionization loss of charge in the behavior of the static electricity as the interfacial surfaces separate in this manner, the voltage across the lengthening gap between the separating surfaces would increase indefinitely. This, of course, it does not do.

In industrial operations, both of these discharging processes, together, react to restrain and circumscribe the voltage rise to some degree as the separation of the electrified surfaces increases.

Fire and explosion hazards are the most serious electrostatic problems, and these hazards exist when electric sparks are created in working areas where vapors of flammable products are present. Electrostatic sparks are most commonly initiated by induction where one of the electrified substances approaches a grounded conductor to which it sparks.

By induction, electricity of opposite polarity to that of the nearby electrified substance appears on the grounded conductor. If the voltage between the two exceeds the breakdown potential gradient of the air, a spark occurs. The ignition energy in the spark is a function of both the magnitude of the induced voltage across and the capacitance of the two oppositely electrified electrode areas.

The energies in electrostatic sparks necessary to ignite many flammable mixtures are so small that they are designated in tenths to even thousandths of a millijoule, a millijoule being a thousandth part of a joule or watt-second of energy.

Electrostatic sparks of ignition intensity for flammable vapor-air or vapor-oxygen mixtures may be created by the flip of a sheet on an operating table, by the handling of a rubber tube or re-breathing bag, by sudden spurting of gases through orifices from their cylinders by improper manipulations of valves, by the rubbing of garments on a stool in certain instances, or by walking on improperly constructed or conditioned floors, especially with non-conductive footgear. Igniting sparks in hospital operating rooms may be caused by differences of potential as low as 1100 volts.

Critical Safety Elements in Hospital Operating Rooms

In principle, the elimination of electrostatic hazards in operating rooms resolves itself to the provision of suitable conductivity into each and every facility within the operating room, including especially the flooring and the clothing and footgear of the personnel. In regard to flooring, moderately conductive properties are preferred to high conductivity. With conductive qualities provided throughout, no accumulation of static electricity can exist on facilities within hospital operating rooms; and, hence, no electric sparks can occur to ignite ambient flammable mixtures.

In practice, such provisions of conductivity within operating rooms, while recognized as essential in implementing the inexorable tenets of safety and thus in eliminating all electrostatic hazards, seem not to be regarded as gravely as the jeopardy of the situation requires.

The safety provision that operating-room personnel

[1] "Static Electricity in Industry," Robin Beach. *Electrical Engineering*, Volume 64, May 1945, Pp 184-194.

unfailingly change into cotton garments throughout and use conductive footgear before entering the hazardous areas of hospital operating rooms should constitute an inviolate regulation of every hospital and one that should be demanded of each and every member of the operating staff.

Although conductive rubber coverings on mattresses and conductive rubber sheets and pads for operating tables are available and extensively used, these and other associated facilities, such as sheets, pillow cases, and blankets, when dry, may generate dangerous potentials when they are flipped on or off operating tables in the many ways practiced by nurses and doctors.

Sheeting and other cotton goods used on operating tables should be rendered reasonably conductive by some acceptable means. Unless these problems are resolved, operating tables will continue to remain a focal center of incipient hazards within hospital operating rooms.

The rubber tubing, re-breathing bags, and other such specialized appurtenances used in the re-breathing techniques of applying anesthesia are still largely dielectric and, as such, they constitute particularly susceptible instrumentalities for the generation of dangerous electrostatic potentials. Rubber facilities seem not to be sufficiently developed as yet, conductive-wise, to meet satisfactorily the exacting requirements of anesthetists in providing superior anesthetizing service and enduring conductivity. Also the rubber gloves used by surgeons in operating rooms, until made conductive, will doubtless continue as incipient sources of electrification.

The practice by surgeons and their assisting personnel of dusting into their rubber gloves talc powder and other dispersions which are highly dielectric should not be permitted in operating rooms. Films of talc, accumulating on the floor, develop sufficiently high resistance to render conductive flooring almost non-conducting and, therefore, hazardous.

Most of the facilities in operating rooms, other than the operating table, are portable and are provided with rubber casters or rubber leg tips. The casters and leg tips, of course, are composed quite generally of conductive rubber with the thought that their contact resistance to floor is low. However, this is far afield from factual evidence where commonly contact resistances have been found at dangerously high values.

Drag chains of various types, attached to portable equipment for the alleged purpose of providing grounding contact with flooring, have been shown by repeated tests to possess little, if any, value as a grounding agency. The separation of the dangling links constitute an ignition-spark hazard during electrostatic discharge; and, in the interest of safety, the use of all such chains should be abandoned.

Safety Floors in Operating Rooms

The scientific philosophy which is basic to the recommended use of conductive safety floors in hospital operating rooms stresses the provision of conductive intercoupling between all operating-room equipment and personnel for the elimination of any differences of electrostatic potential.

Proper inter-coupling by appropriate and well-maintained conductive flooring is the priceless key to effective control of almost all of the electrostatic hazards currently existing in hospital operating rooms. The NFPA Committee on Hospital Operating Rooms is to be complimented on its propitious recognition and adoption of conductive flooring for the resistance-controlled ground plane to serve as the inter-coupling agency between all floor-borne equipment and personnel.

In order to translate into safe practice this basic concept of NFPA, however, certain factors relating to it require close analytical scrutiny and sound engineering judgment, born of specialized experience and related research. Some of these pertinent safety factors are: 1—upper and lower safe resistance limits for operating room floors; 2—problems in measuring the resistance of operating room floors; 3—important characteristics of homogeneous resistance for floors; 4—use of alarm signals as an educational requisite in detecting and controlling electrostatic hazards; and, 5—educational and training programs for the instruction of operating-room personnel in acquiring safety consciousness and observing safe practices in their day-by-day service. ★

This paper was presented at the Mid-Winter Technical Meetings of the American Institute of Electrical Engineers on January 31, 1956.

Duties & Privileges of Medical Technologists

by ALPHONSE M. SCHWITALLA, S.J. ■ President-Emeritus, The Catholic Hospital Association

THE MEDICAL TECHNOLOGIST is truly a "sentinel of truth" in the hospital.

Medical diagnosis is essentially a process of finding the truth concerning the patient's condition; medical care of the patient by the physician consists essentially in modifying the condition of the patient as revealed by the diagnosis. The physician cannot achieve the truth about a patient unless all those who participate in the study of the patient, the younger doctor, the nurse, the laboratory technologist, the various aides, are all unquestionably truthful in the assistance which they render the physician. In that assistance they use their best judgment and competence.

Some of this assistance is the result of experience, and hence takes the form of subjective opinion based upon experience. Other assistance, however, is based upon objectively verifiable tests. The ambitions of medicine in its progressive march through the centuries have been prudently and cautiously to reduce the influence of opinion, and to augment objectivity. (This statement must not be understood as depreciating the importance of experience and opinion, but rather as confirming the influence of objective findings.)

The person who has the most responsible significance and authority in enabling the doctor to form his diagnosis is, of course, the laboratory technologist, who therefore necessarily must be a devotee of truth. Unless the medical technologist has a self-disregarding love of truth and a self-mastering drive toward it, medicine of a high scientific and humane standard is impossible.

This, therefore, defines the moral characteristics of the medical technologist. To love the truth is not a simple trait of character. It includes humility, prudence, fortitude, love for work, high but properly restrained and balanced ambition, patience and many other virtues. The exercise of these

virtues in turn will make its contribution to the spiritual motivation of the medical technologist. The laboratory technologist is a person who lives on a high level of moral integrity, motivated in his activities by all the virtues and motives which actuate the physician in his love for suffering humanity.

The work of the medical technologist has vast significance for the social and economic life of the patient. Slovenly laboratory reports and careless laboratory work always means higher costs to the hospital, to the physician, to the patient. Unnecessarily long hospital stays, high costs for nursing service, loss of salaries and wages, worry and anxiety to the relatives and dependents of the patient—all this is all too frequently traceable to negligence, incompetence or a lack of seriousness in the laboratory.

Fortunately, only a person with a strong moral sense and high intellectual endowment will persevere successfully and with joyful satisfaction in the exacting duties of the medical technologist. It must be admitted that even in the sanctuary of the laboratory there are those, at times, for whom the moral exactions of the laboratory yield to desecration and selfish commercialization. For this reason the school of medical technology must teach ethics along with science; for this reason the instructor in medical technology must possess unselfish love of the truth, if she would realize the high possibilities of her teaching duty; for this reason the student of medical technology must grow apace in her spiritual viewpoint, her moral uprightness and her professional ambition if she would realize to the fullest extent the place in life which she can achieve in the practice of her exacting profession.

Finally, there is man's great privilege—research—the discovery of new truth, in which process, too, the medical technologist shares honors with the physician researcher and the scientist. In his allocution to the 10th General Assembly of the International Union of Geodesy and Geophysics, Pius XII calls attention to the debt science owes to the technologist:

"Is it not moving, gentlemen, to think of the fidelity, at times heroic, of some one or other *servant of science* . . . who must remain at his post day and night, at times . . . thanks to him no link will be missing in the records of an investigation."

That is the duty, as well as the privilege, of many a medical technologist.

Laboratory technology is a vocation. Its value, like that of the vocation to the priesthood—or the physician's, the nurse's and the teacher's—cannot be evaluated in terms of a salary or a wage, for one can make no possible evaluation, in terms of dollars and cents, of the virtues demanded of the medical technologist. ★

The form shown at right is a good example of the type of history-taking required of applicants for positions at a hospital operated by the Sisters of Charity.

GOOD SAMARITAN HOSPITAL – CINCINNATI 20, OHIO

APPLICATION FOR EMPLOYMENT

Date of Application _____

NAME OF APPLICANT

_____ Social Security No. _____

LAST NAME FIRST NAME MIDDLE NAME MAIDEN NAME

Present Address _____ Tel. No. _____ FOR WHAT POSITION DO YOU APPLY?

1. _____

Date of Birth _____ Age _____ Place of Birth _____ 2. _____

Height _____ Weight _____ Eyes _____ Hair _____ Male _____ Female _____ Race _____ Religion _____

Who depends on you for support? Give age and relation of each. _____

Marital Status – please underline: Single, Married, Widowed, Divorced, Separated. Are you a citizen of the United States? _____

Name and address of school last attended: _____

Grade completed _____ Certificate or Degree _____

Please list your last 3 employers, beginning with the last:

1. _____
NAME OF EMPLOYER ADDRESS POSITION HELD DATES WORKED SALARY REASON FOR LEAVING

2. _____
NAME OF EMPLOYER ADDRESS POSITION HELD DATES WORKED SALARY REASON FOR LEAVING

3. _____
NAME OF EMPLOYER ADDRESS POSITION HELD DATES WORKED SALARY REASON FOR LEAVING

Name of nearest friend or relative: _____ _____ _____ _____
NAME ADDRESS TEL. NO. RELATION

Give names and addresses of 2 persons, not relatives or former employers who can vouch for your honesty and character:

1. _____ 2. _____
NAME ADDRESS NAME ADDRESS

I certify that my answers to the above questions are true and I agree to submit to a physical examination including a chest X-ray and blood test.

_____
Signature of Applicant

Figure I

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Comprehensive Forms Aid Three

by SISTER ANCILLA, S.C., Dietitian

MATERIAL FURNISHING INFORMATION on conditions existing in training dietary personnel was assembled from a survey of the dietary departments of seven hospitals conducted by the Sisters of Charity, Mount Saint Joseph, Ohio. The survey was conducted among several hospitals rather than one, to present a more complete picture of various methods used by both large and small hospitals to maintain employee interest, efficiency and contentment. The information obtained covers the training program for dietary personnel, including the pre-employment period and in-service program.

The pre-employment stages of the hospitals contacted could be classified in one of three groups: (1) Centralized Personnel Management; (2) Departmentalized Personnel Control; and (3) Placement by Employment Bureau.

Centralized Personnel Management

This was reported as best adapted to the direction of employees in three of the larger hospitals—Good Samaritan Hospital, Cincinnati, Ohio: Good Samaritan Hospital, Dayton, Ohio: and Glockner-Penrose Hospital, Colorado Springs, Colo.

In each instance the personnel for the entire hospital is cleared through the personnel manager.

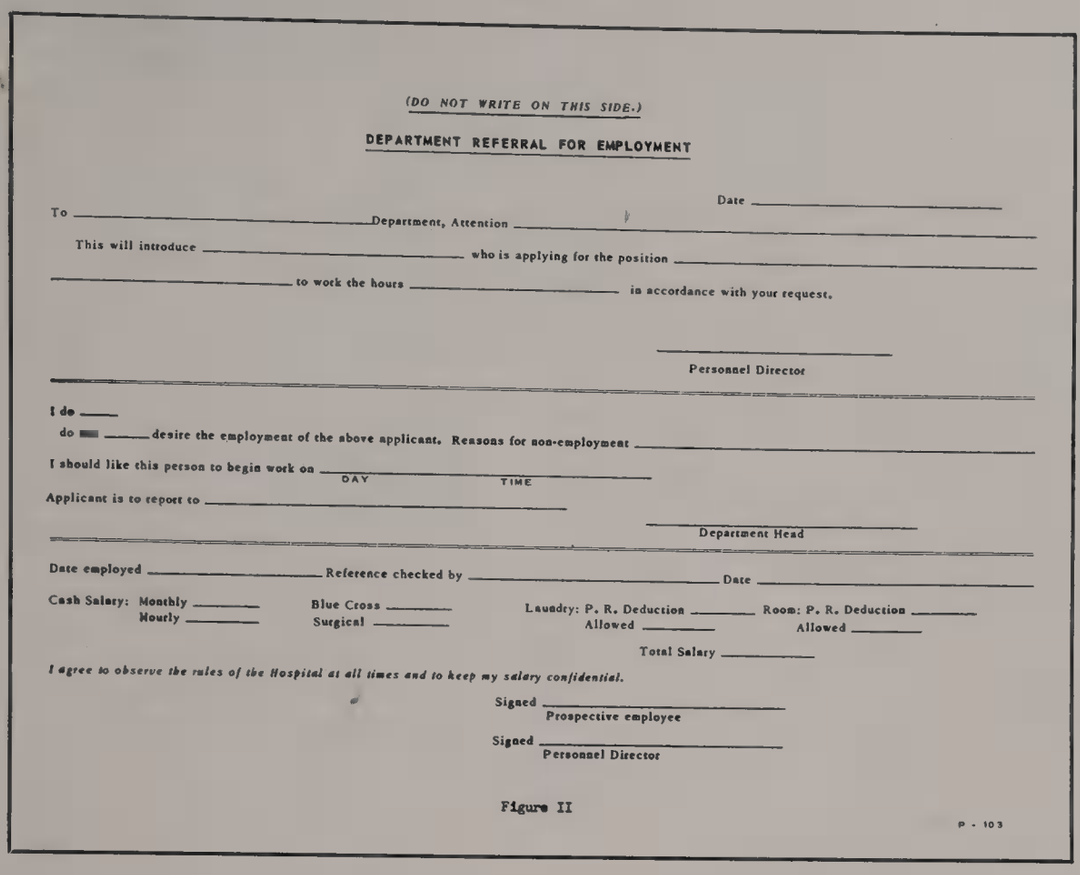
A list of available positions in each department, with a brief job description and stipulated requirements for potential employees, is kept by the personnel manager. A vacancy in the Dietary Department would create the following routine:

1. Request for the employee made by the administrative dietitian.
2. Employee interviewed and screened by the personnel manager.
3. Application filed by the prospective employee.
4. Referral to the Dietary Department.
5. Preliminary acceptance or rejection of employee for interview.
6. Personal interview by administrative dietition.

In screening an employee for the Dietary Department, the personnel manager in each hospital reported that consideration was given to stipulated requests previously made by the administrative dietitian. For example, if a request is made to fill a vacancy in the preparation room, consideration would be given to older women, neat and with at least grammar school education. If the Coffee Shop requests a waitress, characteristics such as neatness, politeness and legible handwriting would be requisite.

The applicant must personally fill out the application. Then referral of potential employee is made to the dietitian by means of the written application.

Good Samaritan Hospital, Cincinnati, Ohio, has made efficient use of an application blank providing the departmental referral on the reverse side. (See figures 1 and 2.) This type of referral enables the dietitian to review carefully the application before personally interviewing the applicant.



(DO NOT WRITE ON THIS SIDE.)

DEPARTMENT REFERRAL FOR EMPLOYMENT

Date _____

To _____ Department, Attention _____

This will introduce _____ who is applying for the position _____

_____ to work the hours _____ in accordance with your request.

_____
Personnel Director

I do ____
do ____ desire the employment of the above applicant. Reasons for non-employment _____

I should like this person to begin work on _____
DAY TIME

Applicant is to report to _____

_____
Department Head

Date employed _____ Reference checked by _____ Date _____

Cash Salary: Monthly _____ Hourly _____ Blue Cross _____ Surgical _____ Laundry: P. R. Deduction _____ Allowed _____ Room: P. R. Deduction _____ Allowed _____

Total Salary _____

I agree to observe the rules of the Hospital at all times and to keep my salary confidential.

Signed _____
Prospective employee

Signed _____
Personnel Director

Figure II

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The form at left provides a facile way of recording recommendations regarding an applicant for employment, as necessary departmental action is taken.

Dietary Employment Practices

St. Vincent Hospital, Santa Fe, N.M.

This form provides efficient control of employees and eliminates countless hours of screening on the part of the dietitian. The personnel manager is always cognizant of the details of the job and the requirements of the worker.

Under this system, the personal interview follows, conducted by the administrative dietitian. The points as summarized were submitted by the hospitals and used as an outline during the interviews. They are:

1. Age
2. Previous experience
   a) How long on previous job
   b) Reason for leaving
3. Suitability of personal characteristics for the job
4. Chances of stability
5. Willingness to learn
6. Personal appearance
7. Courtesy, alertness, pleasantness
8. Health
9. Education

The advantage of the Centralized Method for larger hospitals as a preemployment measure is readily seen, since its limits the interviews made by the dietitian herself to those previously screened by the personnel manager.

Department Control

At Saint Mary's Hospital, Pueblo, Colo.; Mount San Raefael Hospital, Trinidad, Colo.; and Saint Vincent Hospital, Santa Fe, New Mexico, the Departmentalized Personnel Control System is in effect. A routine application for employment is kept within each department. Potential employees generally come to the department to file application for the desired position. A file is kept in the Dietary Department of all available employees, and as a vacancy occurs the applicant is contacted by the administrative dietitian. A preliminary interview is conducted by the dietitian when the applicant first comes to the Dietary Department. When the applicant is called to fill the vacancy a more complete interview follows, using the points previously outlined in the centralized method.

Employment Bureau Referrals

The third method of securing employees, through an employment agency, is used by St. Joseph's Hospital in Albuquerque, New Mexico. The employment bureau keeps a complete file with all the pertinent data for personnel of the hospital and when an employee is needed the agency is contacted. Previously screened employees are then sent to the hospital for further interview by the dietitian. The Dietary Department may not hire employees unless they are obtained through the agency. The personal interview conducted by the dietitian determines whether the employee will be hired or not. If not, the dietitian must again contact the bureau until a satisfactory employee is obtained. This method perforce requires a longer period of vacancy before positions are filled.

In any of the three methods cited, each Dietary Department maintains a complete card file of employees in

the department. The card used is similar to that submitted by St. Vincent Hospital. One side of the card lists the following items: name, address, hours of work, wages per hour, position, telephone number, time clock number, days off, and date employed. The reverse side bears the dismissal date, space for comments, rehired (?) yes or no, and the signature of the department head.

Each hospital's pre-employment program conforms to current health standards by having chest x-rays and blood tests taken before permanent employment is guaranteed. These tests are repeated annually thereafter.

A *Personnel Handbook,* stating the policies of the hospital, is given to each person upon employment at Saint Vincent Hospital. The *Handbook* helps to promote mutual understanding, respect, co-operation, and satisfaction of the personnel in their relationships with the hospital and with one another.

The hospitals' training program proved rather interesting in their similarity toward handling employees following the pre-employment period. Training procedure was in every instance "on-the-job training." All dietary personnel are immediately supervised by a dietitian but the actual training, after careful and detailed explanation of duties, is done by a trained employee.

Five hospitals reported using job analysis or work sheets as a satisfactory introduction and guide for a beginning employee.

Tray room maids (those who assist in serving trays and tending to care of the tray rooms) have regular classes at two hospitals once a week. These classes are conducted by the dietitian and afford an opportunity for general check-up of the tray room equipment and supplies; furnish definite time for instruction on tray service, and provide for careful inspection of neatness and work of the tray room maids. These classes have also been the means of obtaining profitable suggestions for the dietitian from the employees themselves.

EFFICIENCY RECORD: EMPLOYEE _____ DATE _____

ADAPTABLE	VERY	MODERATELY	INADAPTABLE
COURTEOUS	ALWAYS	GENERALLY	DISCOURTEOUS
CONSCIENTIOUS	VERY	MODERATELY	NO
NEAT	VERY	MODERATELY	SLOVENLY
INDUSTRIOUS	VERY	MODERATELY	INDOLENT
PUNCTUAL	ALWAYS	FAIRLY	TARDY
RELIABLE	VERY	FAIRLY	UNRELIABLE
LOYAL TO HOSPITAL	VERY	MODERATELY	NO
LOYAL TO IMMEDIATE SUPERVISOR	VERY	MODERATELY	NO
EFFICIENT	VERY	MODERATELY	WASTES TIME
ATTITUDE TOWARD PATIENTS	GOOD	FAIR	BAD
INITIATIVE	GOOD	NOW AND THEN	LACKING
ABILITY TO TAKE CRITICISM	GOOD	FAIR	RESENTFUL
ABILITY TO CO-OPERATE WITH FELLOW EMPLOYEES	ALWAYS	NOW AND THEN	LACKING
ABILITY FOR ASSIGNED JOB	GOOD	FAIR	BAD
PLEASANT TO WORK WITH	YES	MOST OF THE TIME	NO
ABILITY AND WILLINGNESS TO INSTRUCT CO-WORKERS	GOOD	FAIR	UNWILLING-UNABLE
CAPACITY TO ANTICIPATE	GOOD	FAIR	BAD
WILLINGNESS TO DO LITTLE THINGS OVER AND ABOVE THEIR ASSIGNED JOB	YES	NOW AND THEN	NEVER

REMARKS _____

DEPARTMENT HEAD _____ APPROVED _____

EMPLOYEE _____

Figure 3

An efficiency rating record is an incentive to progress by employees.

All hospitals reported the use of uniforms in their departments. Different colors were used in the various units within the department.

Transfers are made within the department for one of two reasons—first, for a promotion and secondly, if the efficiency of the department demands it.

An important factor used in three hospitals to provide additional incentive to progress in the efficiency of the individual is maintained by an employee evaluation record.

This record is submitted to the Dietary Department by the payroll clerk every six months previous to increase in salary. (See Figure 3.)

In summarizing the survey it can well be noted that an important part of the dietitians' duties is to maintain an efficient, co-operative and cheerful group of employees. This is done by a carefully planned pre-employment program and thorough orientation to the job and other personnel by the dietitian.

Dietary personnel within a small or large hospital present an interesting but continuous job for the dietitian for she must over exercise good judgment, courtesy, patience, sympathy and understanding. ★

HOUSEKEEPER SHORTAGES . . . . .

by **FRANCES PENFIELD, Chief Housekeeper**
VA Hospital, Newington, Conn.

NEED FOR EXECUTIVE HOUSEKEEPERS trained in hospital procedures is great. A large number of hospitals have no housekeeper at all (although some of them may have a head porter or comparable individual whom the administrator has dignified with the title of housekeeper).

Why does this situation exist? Is it the very rapid expansion of hospital facilities, creating circumstances which force the administrator to turn attention to even more pressing concerns? If this is the case, the organization of a central housekeeping system may have to be postponed temporarily until there is time to cope with the problem and to find someone who is familiar with what it entails if (as is often the case) the administrator is unschooled in it. Today's hospital housekeeping must have someone trained in organization, someone forceful enough to implement her ideas and efforts—yet diplomatic enough to create a department with a positive approach so that respect and co-operation from other departments are enlisted.

It should be organized to the point where personnel failures resulting from illness or absenteeism can be covered at all times with alternate personnel so that the nursing service can function without its members having to take over housekeeping duties.

A definite line of demarcation should be drawn so that everyone in the hospital family will know what his or her duties are, thus avoiding conflict between departments. Work sections should be decided upon, and duties for these sections laid out and timed. In addition, an overall picture should be drawn so that all work carried out on a yearly basis is included and arranged for in advance. Reliefs should be worked out to insure seven-day coverage where a five-day work week is in effect.

Even housekeepers with experience and training are not always able to meet the requirements of organizing a department where none has existed, regardless of how skilled they may be in routine executive work. Organization, particularly on a very large scale, is a new requirement, and many housekeepers need strong, understanding support from their administrators. If the executive housekeeper is made responsible only to the administrator, who is alert to the great importance of this post, the whole expense account of the hospital would reflect this arrangement, and over-all costs would go down.

St. Expeditus Hospital

Dear Sister Michaeleen:

Just got back from my daily visit to Pediatrics. Must have been "shot" time. There wasn't a dry eye in the place. No visitors are allowed in the ward--and those babies like to be picked up. I know. I've tried it. But putting them down again is another story.

Which reminds me--Sister Mary Jerome had company last Sunday. One visitor was her third-grade niece, Sheila Marie. During the course of the visit, Sheila Marie wandered off to the chapel, said the Stations, went down to the cafeteria, had a Coke and in general gave herself a self-conducted tour of the institution.

When she returned to the convent parlor, Sister Jerome asked her where she had been. Sheila Marie responded, "Oh, I went to the chapel to say the Stations."

Sister Jerome commented, "Why, I could have said the Stations three or four times, in the time you've been gone."

Sheila Marie came back, "But I say mine with devotion!"

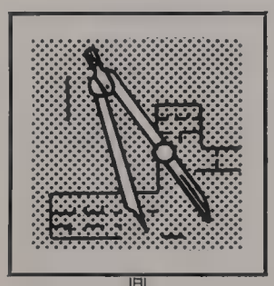
We closed our Forty Hours two weeks ago. A Benedictine Father conducted it. Being Benedictine, he centered his themes around the Liturgy, and from what the girls tell me, he really did a good job on showing the connection of the Mass and Blessed Sacrament with every-day life. Students have even asked Sister Rita Ann if they couldn't join with the Sisters in singing High Mass. And I've noticed that even the graduates are making more frequent visits to the chapel before and after coming off duty, or stopping by when they go back to the floors after a "coffee break."

We had our closing at 4 p.m. Sister Rita Ann gave a little talk, as she usually does, welcoming the padres, emphasizing the hospital as a part of the Catholic Church, and welcoming any suggestions from parish priests about the service rendered by St. Expeditus Hospital or any ideas they might have on increasing the "Catholicity" of the hospital.

A number of out-of-town clergy were present, and their comments on some of the relations they had had with Sister-administrators weren't particularly complimentary. They weren't especially worried about the internal policies of the hospitals concerned, although one padre did remark that the nuns should be given courses on practical psychology and the Papal teachings on social justice. What seemed to bother them the most is the indecision met when an individual hospital was faced with a problem involving in a way the whole Catholic community. In the two cases cited, the Sisters called in a lot of lay advisers but never once contacted the local pastors involved. As a result, when the pastors were asked for a comment, they were put in the embarrassing position of stating that they had no comment to make, since they had not been informed as to what policy had been decided upon by the Sisters.

It's a problem. And it involves a double-take. It's one thing to write a story for the diocesan press on what a Catholic hospital is, and it's another thing to write the same story for the local lay press. In Christ through Mary, your brother,

Father Brian



Construction and Maintenance of Hospital Buildings and Equipment

by **ROY HUDENBURG, Associate Administrator**

THOSE RESPONSIBLE for the finances of hospitals will, of course, be interested in how hospital planning affects the income and expense statement. Some minor computations easily demonstrate that proper hospital design can pay big dividends. The computations to consider are these:

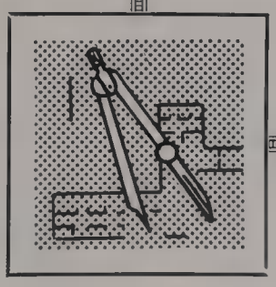
Given: Patient day cost—$20.00; Occupancy—85 pct.; relationship of payroll to patient day cost—61 pct. Total payroll per bed in five and half years is $20,801, or the equivalent of construction cost per bed.

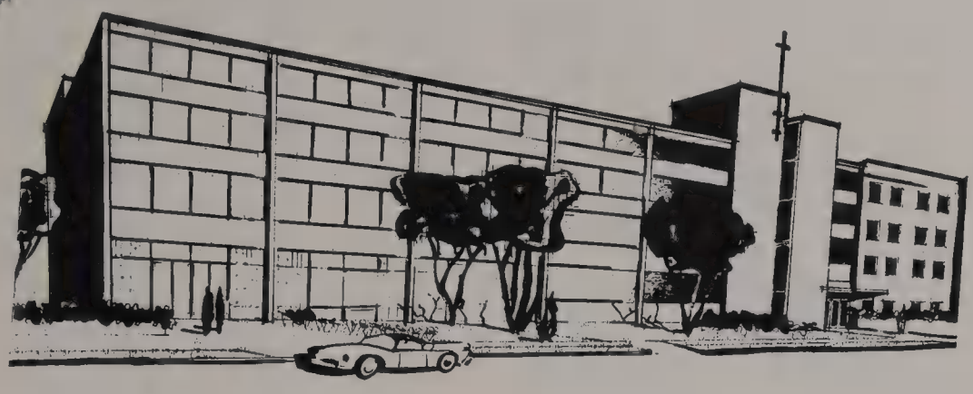
Let's look at it another way: Minimum weekly salary—$30; Minimum salary for one employee for five and a half years—$8,580.

I submit, therefore, that if the payroll for the operation of one bed of a hospital in five and a half years aggregates the total construction cost for that one bed and if the minimum salary that might be paid to an employee over that five and a half year period is $8,580, we can well afford to invest that amount in planning or construction that will result in the saving of just one such salary. It must be remembered that when, through that saving of a salary, the investment has been recaptured in five and a half years, the additional savings from that point on constitute a continuing reduction of the cost of patient care.

The figures quoted are obviously not based on principles of the capitalization of an investment, but they do illustrate dramatically the value and necessity of proper planning for functional operation.

The principle ideals with which a building program is approached are probably three-fold: (1) To provide the medical staff with the modern facilities necessary for their work; (2) to make it possible for the nursing profession to give the best possible bedside care; and (3) to make all supplies available to the nurses where they need them, and at the least possible cost. (There are minor problems and minor areas of concern which might include ease of cleaning, ease of maintenance and, of course, ease of performing clerical duties — but the three





The architect's sketch of a proposed structure may look attractive enough when it graces a prospectus—but the institution's true test will be the suitability, durability and functional relationship of the elements within, under conditions of actual *use*.

Memorial Hospital Association of Kentucky ● Washington, D.C.

principal ideals just enumerated are those which should control the large fundamental planning decisions for the new hospital.)

The functional relationship of hospital elements is most important in planning facilities for the use of the medical staff. For instance, during the development of the Hill-Burton program it has been possible to trace a growing tendency to locate surgical suites on the main floor of hospitals of less than 200 beds.

Architects for our own program which will serve members of the United Mine Workers of America, have developed various architectural solutions that place the surgical suites on the main floor. This is not an accident or a fad. It stems from the fact that good medical care requires a close relationship of the operating room to the emergency suite and to the x-ray department.

In this same relationship, the emergency area calls for an intimate relationship with the admissions department, which in turn in the smaller hospital bears an intimate relationship with the outpatient department and the medical records area. Therefore, a typical architectural solution calls for a wide expanse of first floor area.

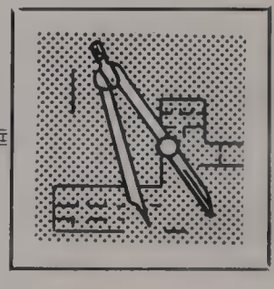
Let us not worry about the details of planning the internal operations of the various departments. They are matters that will fall into place after broad principles have been settled.

Good planning evolves around basic principles of providing effective bedside care and supplying materials for the use of the nurse at the least possible cost. In the most recent years the concept of team nursing has completely changed our approach to the layout of the nursing floor.

Whereas old standards limited the size of the nursing unit to 25 to 30 patients, we now limit the size of the nursing unit only by the radius of maximum distance from a point of supply to the most distant bed. Thus in our program we supply any number of beds from 50 to 86 from one utility room and one nurses' station on the floor. This is only possible because a specific number of patients become the charge of one team of nursing personnel.

Actually we would not feel that we could work this out effectively if we had not developed a new pattern of patient-nurse communication. It is all very well to have a floor clerk who can accept calls from 60 patients during the day and see that patient wants are handled with dispatch. But in the midnight hours when the nursing staff is limited, patient care would present great problems, were it not for the fact that we have developed remote corridor stations from which the night nurse can answer every patient call originating anywhere on the floor without returning to the main nurses' station.

The service of supply as we see it must take advantage of vertical communications, using carts distributed by elevator for routine supplies and individual trays or individual items distributed by dumbwaiter for emergency wants. This feature, of course, calls for an investment in mechanical facilities that far over-shadows the mechanical systems installed 15 years ago. This type of planning is intended to keep the nurse and the nurse aide on the floor, taking care of the patient—not wasting time performing messenger



services, a function for which she is far too valuable.

Because all these planning considerations are so closely allied with the conservation of personnel, conservation of the operating dollar and the improvement of patient care, careful selection of the planning team normally includes a hospital consultant, and an architect.

Before the architect can undertake his work for the future hospital, the officials of the hospital must decide on their building requirements. Very few individual hospital organizations can look at their own problems with sufficient objectivity to determine their needs and to develop a pattern of balanced facilities to provide the best service to the community and the medical staff. Some impartial judge must develop an over-all program, perhaps based on what facilities can be bought within today's construction budget and what other facilities must be postponed for building tomorrow. These are the areas where the consultant performs his maximum service in the building program.

With this broad pattern of a program settled it becomes the joint responsibility of the consultant, the administrator, and the architect to write an architectural program which spells out 1) square foot areas itemized for individual functions; 2) individual departmental requirements such as recovery room facilities, dayrooms, treatment and conference rooms; 3) interior finishes and 4) mechanical requirements. No actual layout should be attempted until such an architectural program is written.

The next step is the architect's development of schematic arrangements that can make this architectural program a reality, and then the development of preliminary drawings, during which the consultant plays his part by advising on internal departmental layouts. Once these preliminary drawings are jelled and firmly adopted, the job becomes one for the architect, who develops working drawings and specifications which will become the contract documents in the awarding of the contract.

Two principal measures may be applied to the person being considered for consultant: His over-all philosophy with respect to the program of medical care and patient care, as previously exhibited by the consultant, must be compatible with the aims of the organization employing him; Second, he must have demonstrated his ability to work on an extremely close cooperative basis with both the hospital groups he represents and the architects with whom he must associate himself.

These are factors that can only be judged through a close interview with the individual and personal discussions with previous clients. It goes without saying that he must have an acceptable background of experience. Background information on consultants can be secured from the American Association of Hospital Consultants, to which many such men belong.

The architect should, first of all, have an organization of sufficient capacity to develop the necessary work in the course of planning. Over-all architectural development requires a number of skills: Those of basic design, those of working drawings details, those of specification writing and those of supervision. This multiple responsibility calls for an architect whose practice includes buildings of a scope comparable with that of the hospital.

It is most desirable that the architect doing the job have a knowledge of hospital design. The degree of his co-operation, skill in development of drawings and skill in business arrangements again can only be determined by personal interviews with previous clients. The architect cannot be selected on the basis of the good fellowship he exhibits on casual acquaintance. On the other hand, the mere fact that the architect has done *x,* number of hospitals does not qualify him either, if inquiry among his former clients indicates that the hospitals he has built do not function according to modern standards and requirements.*

There are two approaches to contracting for the erection of the building. Both have their advantages and disadvantages. The most common procedure is to submit all the working drawings, mechanical drawings and specifications to a number of general contractors for bids. On this basis the bid is then let to the low bidder for a fixed sum. This method has the advantage of assuring the hospital organization that—on the day it lets a contract—the building will be erected for a fixed known sum. It has the disadvantage that it does not include the general contractor as a member of the planning team and does not secure his advice on how construction economies might be served.

To secure this type of advice and contractor's assistance, it is necessary to choose a contractor as you would the architect or consultant, on the basis of his reputation and past performance as personally checked. When he has been so chosen he can work with the architects in developing methods of construction, reviewing interior finishes and advising on similar problems, all tending to secure a better building or reduce total cost. When this method is used, it is customary to arrive at an agreed budget estimate and to pay the contractor a percentage of that budget estimate as a fixed fee. Under this cost plus fixed fee arrangement, the contractor is normally given a share in any savings if he builds for less than the agreed figure, but there is no guarantee that the building will not cost more because of unforeseen circumstances. Obviously if conditions beyond the control of the contractor cause the building program to be lengthened, over-head on the job will continue during such delays and result in higher building cost. Under this program the general contractor acts as the agent of the hospital in awarding subcontracts. In general, however, while this system does have advantages, it is best avoided unless the architect is accustomed to building under this arrangement and can advise his client as to the pitfalls to be avoided in the drawing of the necessary contracts.

While there are these obvious disadvantages to the cost plus fixed fee method of contracting a construction job, it must be remembered also that the procedures in the awarding of a lump sum contract on competition are not without their pitfalls. It is a common requirement of government agencies that bids must be advertised and the bidding documents made available to any prospective contractor capable of posting the necessary bond.

There are contractors and contractors. Some are honest and competent and well organized. However, if they are incompetent or do not possess the necessary organization to carry out a large project, the building still may suffer despite their obvious honesty. Therefore, it is necessary, unless the job is being bid under governmental restrictions, to select carefully in advance, those contractors who are to be

*The American Hospital Association maintains a list of architects who have demonstrated their knowledge of hospital architecture. This is available on request.

permitted to bid. Many construction jobs have also suffered—and suffered badly—because the general contractor, honest though he was, awarded subcontracts to incompetent subcontracting firms.

With the building under way, the next problem the hospital officials face is: *How do we equip the building and how do we furnish it?*

The answer to the first of these questions depends to a great extent on the available planning and purchasing talent within the organization. There is some tendency to contract with a supply firm which will undertake to supply at "cost plus a fixed fee" all merchandise that is not the subject of price control by the manufacturer. On price-controlled items, under this arrangement, the fixed fee does not apply. With this service the hospital supply company provides a great deal of planning talent, relieving the hospital organization of much deadly, tedious estimating of future requirements.

However, unless the hospital organization actually measures its equipment requirements in advance, it cannot be sure until it is actually operating its new structure whether the judgment of the hospital supply firm making up the equipment list has been sound. Indications are, of course, that the more responsible companies engaging in this work have adequate backgrounds to enable them to make satisfactory estimates. On the other hand, the hospital which is a going concern with responsible department heads capable of establishing equipment lists and with a well-qualified purchasing department may well feel that it can operate more effectively by procuring its equipment on a competitive bid basis.

In the selection of furniture we are becoming more and more concerned with interior effects and again there is a growing tendency to employ interior decorating consultants who can also act as agents of the hospital organization in procuring furniture. There are fairly well-defined rates for this service under which the consultant does the color schemes, selects draperies, provides for their manufacture and on behalf of his client buys the furniture at factory cost, above which his client pays freight, plus the agreed commission to the decorator. The disadvantage of this system is that while all the problems of interior decoration are covered under the decorator's commission, the arrangement precludes dealing with firms who have a policy of selling direct to hospitals at a fixed cost and will not recognize the decorator's right to a commission. The other side of this coin is that frequently the

architect is quite willing and capable to give complete assistance on color and furniture selection. However, when the architect does provide this service the hospital must then solve the problem of how to secure the lowest possible price on the furniture selected, which in turn calls for an active and adequate purchasing department.

This discussion sped lightly over the question of the determination of hospital needs in relation to the community. It is hardly necessary to call attention to the activities of the state planning agencies under the Hill-Burton program. In deciding on new building needs it is then necessary to understand the state agency's listing of unmet need for beds in the community, not only in terms of the gross number of beds needed, but also in terms of the distribution of hospital facilities within the community.

It may be folly, for example, to undertake to provide too many beds in a central location in a rapidly growing town where future hospital needs are obviously going to be in an outlying location. As a matter of fact, the investment of construction funds in such a central location may well be jeopardized if a general survey of the community indicates that the current location is in an area due for an industrial and slum blight.

Construction must be geared to the plans of the medical staff and to known plans by other hospitals to add to their facilities. In its comprehensive planning, a hospital above all must be extremely community conscious if it is to serve in its true function as a community health center.

A question undoubtedly of paramount interest to those contemplating hospital construction is: *How much will it cost us to build?*

It can be said with no facetiousness that you will know what it costs you to build when plans have been completed and the contractor's bids are in. Costs per square foot can be anticipated to some extent, but they will vary with the size of the hospital, the completeness of its facilities, and its density of planning.

There is no question in my mind but what a compactly designed hospital planned with the utmost space conservation will cost substantially as much per bed as a hospital planned with somewhat more liberal allocation of area, although, of course, its square foot cost will be higher. In today's market I judge that $20,000 a bed would be a minimal allocation of funds including fees and furnishings, and that the budget might be better planned on an allocation of $25,000 per bed. A small well-built hospital may run above $25,000 a bed. A fair estimate of square foot building costs might be in the vicinity of $25 to $27 per square foot.

The next question that might well be asked is: *What is the outlook for the future in hospital construction costs?*

To answer this, look to the past. In 1939 the construction cost index for institutional and office buildings was 130.7; by 1951 this cost index had doubled and the figure stood at 263.7; by 1953 the cost index had gone to 281; the cost index now stands at 294. The conclusion seems clear for anyone to read—a steady increase in building cost can be anticipated as long as the present economic cycle is maintained. Since at the moment there appears to be no highly alarming signs weatherwise in the economic skies, there is no reason to believe that construction costs should soon become any more favorable and there is every reason to believe that delays in construction are likely to bring added cost. ★

For M.R.L.'s: Toleration or Appreciation?

by ROZENE McCLELLAND, R.R.L. • St. Luke's Hospital, St. Louis, Mo.

The accompanying article was prepared from a talk given by Mrs. McClelland, R.R.L., of St. Luke's Hospital, St. Louis. Mrs. McClelland is president of the Missouri State Association of Medical Record Librarians. The talk was so well received that we requested permission to use it in H.P. Written in a light vein, its serious underlying message indicates services which an administrator is all too likely to forget.

A PSYCHIATRIST of my acquaintance once remarked that anyone in the medical record profession had to have an obsessive-compulsive personality. I'll go along with him on that, because we do have to have an almost psychotic drive to keep things in order. However, the greatest danger to the mental health of the medical record librarian is that she will become paranoid. How can she help it, when merely walking toward a nursing station brings forth groans and "What have we done wrong, or not done, now?" from the nurses. This reaction occurs all over the hospital. I imagine even administrators sometimes wish the medical record librarian would stop forwarding their problems.

Because we are incipient paranoids, we often feel that the administrator looks upon us as a financial liability and a necessary evil. We feel that the Nursing Department, from the director to the newest student, considers us as file clerks or keepers of dead records which have no real connection with the true purpose of the hospital—the best patient care possible.

"Ventilation" is a basic measure in psychotherapy. This article is an application of that principle. And while they read this, I would like administrators and nurses to assume the role of the therapist and listen with detachment and understanding to the basic needs and desires of the medical record librarian.

So what if the Medical Record Department doesn't bring in any ready cash? Does the administrator realize all the services we have to offer? He (or she) relies upon us to collect statistics for the Joint Commission on Accreditation of Hospitals, the American Medical Association, the American College of Surgeons, the medical staff, et al. But is it realized that we are one of the most important public relations spots in the hospital?

We help keep the doctors happy. Our promptness in medical correspondence with other hospitals affects the hospital's reputation. Insurance companies quite often base their judgment of the hospital on the co-operation given in processing claims. Patients seeking information for delayed birth certificates or transfer of medical information to a new attending physician have their attitudes influenced by the manner in which it is given.

We are expected to keep our own records well, but how many times is the medical record librarian's knowledge of methods, filing systems and forms utilized in other departments? Time and money can be saved by simpler and up-to-date methods, and the avoidance of duplication of effort. Start asking around as to why various departments keep certain records—chances are they can't tell you.

The medical record librarian's daily analysis of records makes her cognizant of trouble spots in the various medical service departments. Most of these are easily straightened out if she feels free to bring them to the administrator's attention; e.g., if part of the routine lab work is consistently missing, she knows it first.

We also know of any violations of staff by-laws in the matter of consultations, sterilizations, and such, and are likely to be the one person in the hospital who can bring this knowledge to the administrator.

To nurses, we would like to say that we, as a professional group, have the same motivation of service to the sick, and that we also are deeply concerned in helping care for *our* patients.

Some services we can offer are:

1. Time savers: Re-admission records sent to the division with the patient can cut down on telephone calls to the Record Department and keep the interns happier, besides serving the patient better.

The nurse should have no responsibility for putting the record in order and getting it completed if the medical record librarian does her job properly, but any help she can give is appreciated.

2. Teaching material: There is no substitute for good medical records in case studies by student nurses. As a matter of fact, most schools of nursing don't utilize them as often as they could. Nurses interested in research on a specific problem could use records for group studies as the doctors do.

3. The medical record librarian can be used as a teacher of the essentials of good recordkeeping by schools of nursing, but how many times are her services utilized?

4. Legal protection for the nurse: Careful checking of the nurse's section of the record—for doctor's signatures on verbal orders, the nurse's signature in vital spots, or the recognition of gross errors in charting—protects both the nurse and the hospital.

5. The statistics we ask you to help us collect in the daily census by services are valuable to nursing schools in accreditation reports and to individual nurses who seek reciprocity or transcripts for advanced study.

The medical record librarian thrives on work, so if the one in your hospital shows signs of paranoia, just let her be of more service to you. ★

Nursing News and Notes

This column is a potpourri of items we thought you'd be interested in—evidence that there's nothing really new under the sun, coupled with what we think may be news to most readers.

There were no antibiotics in the fourteenth century, no steam carts, no supervisors' meetings, but apparently Religious nurses then had a definite policy about the care of the sick which does not differ essentially from what might be stated today. The following paragraphs appeared in *Salvator Mundi Quarterly,* published by the Sisters of the Divine Saviour, Rome, Italy:

NURSING DIRECTIVES

[Proposal of the Blessed Johannes Ruysbroek (The admirable—1293-1381. The Founder of the Flemish School of Mystics)—translated Extract from *De Deptem Custodiis Libellus*]

"Brother, if you are in ecstasy, exalted like St. Peter and St. Paul, or whatever example you wish to take, and you hear that the sick are in need of warm soup or any other assistance, I here give you counsel: leave your meditation immediately and come down to earth and warm the soup.

"When you are engaged in the nursing profession, know that your first duty is to manifest a cheerful disposition. Your face must show openness and friendliness, and thus your actions may be perfected. Never must you show the least bit of impatience with the sick. When they are irritable or annoying, then think, "In this moment I am serving Our Lord Jesus Christ." You must favor the poor, those who suffer most, and the desolate; see God in those whom you serve. I beseech you to avoid even the shadow of a word or movement which might disturb the patient. When sadness or irritation takes possession of them, then show them God and the Saints in their heavenly glory, and tell them how they also had to suffer. If the patient asks for something, do not let him wait one minute. If a patient asks for something which is dangerous for him and is contrary to his well being, act as if you did not understand him; if he insists tell him of your apprehensions, and if he persists, then consult your superiors.

"Every time that you prepare a diet or medicine for your patient, do so with the greatest cleanliness, and present it in an appetizing manner. Keep the patient content, and as far as lies in your power preserve peace. Make it a point to often shake the pillows, straighten and refresh the bed. Especially make comfortable the critically sick and those who need the most care. If necessary, remain the whole night at the bed of your patient, but be equipped with vigilance and serenity. Concentrate on how you can distract the patient from his ailment. Make him laugh; read about the words and deeds of our Divine Savior or from the Lives of the Saints that is, when the patient is so disposed. Above all, wherever you are and whatever you do, your presence must bring spiritual joy."

N.L.N. ACCREDITATION

Full accreditation was granted to nine Catholic schools of nursing when the N.L.N. Boards of Review met in December, 1955. One basic degree program was fully accredited as preparing for beginning positions in public health nursing, and eight hospital schools offering diploma programs were accredited. In addition, two previously accredited basic degree programs were approved as preparing for beginning positions in public health nursing and one graduate nurse program was approved as general nursing, preparing for beginning public health. One school was approved for temporary accreditation.

SCHOOLS APPROVED IN DECEMBER, 1955

Full Accreditation

Diploma

St. Francis School of Nursing, Grand Island, Neb. Poor Sisters of St. Francis Seraph of Perpetual Adoration.

Mary's Help School of Nursing, San Francisco, Calif. Daughters of Charity.

St. Joseph School of Nursing, Phoenix, Arizona. Sisters of Mercy—Our Lady of Mercy.

St. Joseph School of Nursing, Fort Wayne, Ind. Poor Handmaids of Jesus Christ.

St. Anthony School of Nursing, Carroll, Ia. Franciscan Sisters of Perpetual Adoration of the Third Order.

St. Joseph School of Nursing, Denver, Colo. Sisters of Charity of Leavenworth.

Catherine Laboure School of Nursing, Boston, Mass. Daughters of Charity.

De Paul School of Nursing, St. Louis, Mo. Daughters of Charity.

Degree

Georgetown University, Washington, D.C. Society of Jesus and Sisters of Charity of Nazareth. Full accreditation with beginning public health approval.

Loretto Heights College, Denver, Colo. Sisters of Loretto. Approval for beginning public health granted to fully accredited program.

Marquette University, Milwaukee, Wis. Society of Jesus and Franciscan Sisters, Daughters of the Sacred Heart of Jesus and Mary.

TEMPORARY ACCREDITATION

Providence School of Nursing, Holyoke, Mass. Sisters of Providence.

With these additions, 27.8 per cent of Catholic schools of nursing offering basic programs are fully accredited, eight of them for beginning public health, 63.0 per cent hold temporary accreditation, and 9.2 per cent are not nationally accredited.

Sister M. Geraldine Honored by St. Louis University

Saint Louis University honored the former dean of its School of Nursing, Sister M. Geraldine Kulleck, S.S.M., on the occasion of University Founders' Day, celebrated November 15-16, 1955. The only woman to be so honored, Sister M. Geraldine was one of 12 distinguished alumni to receive the alumni merit award. The following citation accompanied the award:

"Her many achievements have won for her the personal respect of the Nursing Profession and brought a national reputation to her Alma Mater—Saint Louis University . . . . During her years as Dean, the School of Nursing was recognized as one of the foremost collegiate schools in the country . . . . Sister served her beloved country as well as her cherished profession as an honorary consultant, Bureau of Medicine and Surgery, United States Navy. Sister brings to her present position as Administrator of Firmin Desloge Hospital a vast experience which guarantees the successful attainment of the aims and objectives of an ideal hospital."

During her term as Dean of St. Louis University School of Nursing Sister M. Geraldine was an active participant in nursing education activities of the Catholic Hospital Association. Sister was a member of the first Council of C.C.S.N., serving from 1948-1951.

PERTINENT POINTS AND PERSONALITIES

■ Sister M. Bonaventure, P.B.V.M., Administrator, McKennan Hospital, Sioux Falls, S. Dak., and a member of C.C.S.N.'s Council, was named President-Elect of the South Dakota Hospital Association at its Fall 1955 meeting.

■ Sister M. Evarista, S.P.S.F., Director of St. Elizabeth's School of Nursing, Covington, Ky. was elected first vice-president of the Kentucky State Nurses' Association at its Fall 1955 meeting. Miss Louise Schoo of the St. Elizabeth's faculty was elected secretary of the K.S.N.A.

■ Sister St. Catherine, C.S.J., Director of St. Mary's School of Nursing, Waterbury, Conn., recently elected president of the Connecticut State Nurses' Association, is the first Sister to hold that post.

■ Sister Olive Marie, O.S.F. has been appointed Dean of Niagara University School of Nursing, Niagara, N.Y. Sister has been serving as acting dean for the past two years.

■ Miss Ruth McGrory, Chairman of the Department of Nursing Education at Canisius College, Buffalo, N.Y., was elected chairman of the E.A.C.T. Section of the New York State Nurses' Association.

■ Sister M. Bernadette, S.S.M., St. John's School of Nursing, Tulsa, Okla., a member of C.C.S.N.'s Council, has been named President of the Oklahoma State Board of Nurse Examiners.

■ St. Francis School of Nursing, Trenton, N.J. celebrated its 50th anniversary on December 10, 1955.

■ St. Francis School of Nursing, Columbus, Ohio, now connected with St. Anthony's Hospital, plans to celebrate its 25th anniversary in 1956. All graduates are asked to send their current addresses to the Director of the School, Sister Mary Philomene, 308 E. Town St., or to the president of the Alumnae Association, Mrs. Anna McCabe, 1068 Kingsbury Place, Columbus 9, Ohio.

■ Students of Sacred Heart School of Nursing, Yankton, S. Dak., are spending some time observing children in the parochial school, under the supervision of the school nurse, as part of their pediatric experience.

■ *Scope*, the house organ of Mercy Hospital, Baltimore, Md., features nursing in its November, 1955 issue. Titled, "Nursing Offers Many Careers," the article is designed to inform about opportunities in nursing other than bedside nursing of which hospital personnel and patients may not be aware.

■ The National League of Nursing has published, "Program Guide for Future Nurses' Clubs," a good reference for high school counselors or teachers who direct such groups.

■ St. Joseph School of Nursing, Fort Wayne, Ind., has another attractive recruitment piece, this one entitled, "There's nothing quite like nursing." We're promised an article soon about their recruitment program.

■ Writing in *The Missouri Nurse*—November 1955 issue, Sister M. Rene, R.S.M., Director of St. John's School of Nursing, St. Louis, Mo., notes that, "People are Good to Student Nurses," and proves it by listing the sources of financial grants to 29 currently enrolled students. St. John's celebrated its 59th anniversary in 1955. ★

PURCHASING AGENTS —Berke

(Concluded from page 46)

that the person responsible for the department is also personally responsible for the errors made in the department, because either the error is due to a misunderstanding, in which case the purchasing agent has given inferior instructions; or it is due to unfitness on the part of the employee, in which case the purchasing agent is at fault in his assignments.

Summary: Co-operation

We may summarize by saying that the purchasing department that does not offer service to the department heads has nothing to offer and, except for certain clerical centralization, has little reason for existence. Personnel must feel free to go to their purchasing agent with problems concerning materials, equipment or service. They will not long continue to go to him if he is a procrastinator, or if he does not keep his promises. If he cannot meet a request he must say so, and give good reasons why he cannot. He must deal fairly with all, and must learn that the hardest thing to do, and yet the easiest way to get the job done, is to work together with people, not at cross-purposes with them. When he has done this, his relationships with his operating department heads will be sound, healthy and rewarding, his job will be easy—and he will be able to claim a close relationship to Superman. ★

SACRED HEART IN SPOKANE, WASH. DEVELOPS A NEW POST-OP DEPT.

by SISTER THEODULA, Administrator
Sacred Heart Hospital, Spokane, Wash.

WHEN THE DECISION was made to open a Post-anesthesia Department at Sacred Heart Hospital, there were many consultations among contractor, administration, and personnel in surgery and anesthesia. We obtained moving pictures from a pharmaceutical company of post-anesthesia departments in other hospitals throughout the nation. These films were reviewed many times, and careful study made of them.

Our Post-anesthesia Department was put into operation on March 21, 1955. We are now able to give closer supervision to the patient during the period of recovery from anesthesia. The staff consists of a head nurse, a senior student, a practical nurse, two graduate nurses and a ward clerk. The department is open from 7:00 a.m. until 6:00 p.m. However, patients anesthetized after 4:00 p.m. are not taken to the Post-anesthesia department. This enables the department to be cleared and prepared for the following day's schedule.

Specialized Equipment

There are 16 special carts and two beds in the department. The carts can be placed in Trendelenberg position by means of a crank and the heads can be elevated to three different heights. They have side-rails and intravenous poles with extensions. Kleenex, emesis basin, knee strap, extra cotton blanket, clip board and pillows are kept with each cart. Only cotton blankets are used in the department.

Oxygen and suction outlets are located on the wall at the head of the carts, so that oxygen is available for every patient and suction for every two patients. The suction can be adjusted for use as naso-tracheal or gastric suction. Sphygnomanometers are wall installations and there is a blood pressure cuff for every patient.

Blood pressure, pulse and respira-

(Concluded on page 66)

Students in X-ray Technology manifest interest in manufacturing processes.

Tours Aid Training

by SISTER M. PATRICIA, S.P.S.F., Superintendent • St. Francis Hospital, Bronx N.Y.

KNOWLEDGE IN ANY FIELD is more readily grasped and retained by students if they can see in concrete reality the context of countless pages of complex—oftentimes abstract—theory. Following the trend of modern teaching methods, visual aids are employed extensively in the St. Francis Hospital School of X-Ray Technology, Bronx, N.Y.

The St. Francis Hospital, located in the Bronx, New York, is an approved, non-profit, general hospital with a bed capacity of approximately 429. The technological school is under the direct supervision of the radiological staff. Resources for operation of this school are insured by the Sisters of the Poor of St. Francis who administer the hospital.

With the ever-ready and timely assistance of the American Society of X-Ray Technicians, the St. Francis Hospital School of X-Ray Technology, after approval by the American Medical Association and the Veterans Administration, admitted its first class of students on March 19, 1955. On September 12, the second class of students was accepted.

Under the protective guidance of our heavenly patrons, St. Joseph and Mary, the Mother of Jesus, our school has been blessed. Like a tiny mustard seed, it is visibly growing and will one day, please God, develop into a mighty tree under whose shade will stand a large number of qualified and certified x-ray technicians ready to serve in the medical field—technicians who will have kept apace with the rapid progress of medical science and engineering as pertaining to radiology in the treatment and diagnosis of disease.

Films; slides; observation in the operating room, morgue and pathological laboratory; experimenting with the electri-kit; demonstrations on the part of service and commercial men—these and others have proved successful visual aids. Most popular, however, among the students are field trips, where education and pleasure combine to make it a perfect "means to the end."

Sister Emmanuel Marie, director of the school, is the first Catholic Sister to hold office in the X-Ray Technological Society of New York, N. Y. At the October meeting of the society she received the appointment of vice-president. ★

Problems in

Accreditation

Standards for Medical Records

The accompanying article was issued over the signature of Kenneth B. Babcock, M.D., Director of the Joint Commission on Accreditation of Hospitals, and is reprinted from the Commission's December 1955 *Bulletin*.

MEDICAL RECORDS are an important tool in the practice of medicine. They serve as a basis for planning patient care, they provide a means of communication between the physician and other professional groups contributing to the patient's care, they furnish documentary evidence of the course of the patient's illness and treatment, and they serve as a basis for review, study, and evaluation of the medical care rendered to the patient. For these reasons the Joint Commission on Accreditation of Hospitals considers the quality of medical records an important indication of the quality of patient care given in a hospital.

Since medical records reflect patient care, the Commission evaluates a medical record on the basis of whether or not it contains sufficient recorded information to justify the diagnosis and warrant the treatment and end results. In agreement with this principle, the Commission has established certain standards of record keeping which it thinks are essential for good patient care.

I. CONTENT

Medical records should contain the following information:

1. Identification Data

2. Provisional Diagnosis

There should be a provisional or admitting diagnosis made on every patient at the time of admission. If a patient requires hospitalization, the hospital staff deserves this information to proceed intelligently.

3. Chief Complaint.

4. Present Illness

5. History and Physical Examination

Only physicians and house staff are competent to write or dictate medical histories and physical examinations. All pertinent positive and negative findings should be recorded. Nurses, medical record librarians, or secretaries should not be permitted to take medical histories.

6. Consultations

Consultations imply an examination of the patient and the patient's record. The consultation note should be recorded and either signed or authenticated by the consultant.

7. Clinical Laboratory Reports

The original signed laboratory report should be entered in the patient's record. Duplicates are filed in the laboratory.

Reports from laboratories outside the hospital are acceptable in lieu of tests performed in the hospital if the following safeguards are maintained:

a. Work is done in a laboratory approved by the city or state. Laboratory work performed in a physician's office by a technician, nurse, or office assistant is not acceptable. Since the hospital is held responsible for the quality of laboratory work reported in the medical record, it must limit outside laboratory work to approved laboratories.

b. The test is recent enough to be pertinent to the individual case. For example, a serological test for syphilis or an Rh determination done any time during the prenatal period will be acceptable. A urinalysis done prior to 48 hours of admission would not.

c. The original laboratory report is made part of the medical record.

8. X-ray Reports

The original signed radiological report should be entered in the patient's record. Duplicates are filed in the department.

9. Tissue Report

Since all tissues removed in surgery are sent to the laboratory, at least an acknowledgment that the tissue has been received and a gross description should be made part of the record. If a microscopic examination is done, a description of the findings should be made a part of the record. Whether or not a microscopic examination is done should be determined by the medical staff and the pathologist according to the rules and regulations of the hospital.

10. Treatment — Medical and Surgical

All treatment procedures should be documented in the medical record. Except in cases of grave emergency, the patient should receive a complete di-

Dr. MacEachern Dies

Readers will learn with sorrow that Malcolm T. MacEachern, M.D., pioneer figure in the standardization program for hospitals, died February 3 in Chicago. A special tribute will appear in the March issue.

agnostic work-up before surgery. Operative notes should be dictated immediately after surgery and should contain both a description of the findings and a detailed account of the technique used and tissues removed.

11. Progress Notes

Progress notes are important in that they give a chronological picture and analysis of the clinical course of the patient. The frequency with which they are made is determined by the condition of the patient.

12. Final Diagnosis

A definitive final diagnosis based on the terms specified in the Standard Nomenclature of Diseases and Operations should be written.

13. Summary

A summary of the patient's condition on discharge and course in the hospital is valuable as a recapitulation of the patient's hospitalization.

14. Autopsy Findings

When an autopsy is performed a complete protocol of the findings should be made a part of the record.

II. SIGNATURES

1. In hospitals without house officers the attending physician should separately sign the history, physical examination, operative report, progress notes, drug and other orders, and the summary. Standing orders should be reproduced on the record and signed by the physician.

2. In hospitals with house officers, the attending physician should countersign at least the history, physical examination and summary written by the house officer. Aside from the fact that this is a legal requirement in many states, it is a protection to the individual physician. It is not considered necessary to countersign progress notes or drug and treatment orders written by house officers. In all instances a physician should sign the clinical entries which he himself makes.

3. A single signature of the physician on the face sheet of the medical record does not suffice to authenticate the entire content of the record.

4. The use of rubber stamp signatures is acceptable under the following strict conditions:

a. The physician whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it.

b. The physician places in the administrative offices of the hospital a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it.

5. Initials in place of a full signature are acceptable provided that the initials can be recognized as having been placed there by a particular physician who can be identified by those initials.

III. OBSTETRICAL RECORDS

There should be a prenatal history and physical examination on every obstetrical patient. If the hospital and medical staff permit and records are of good quality on forms approved by the hospital, a copy of the prenatal record kept by the physician in his office may be substituted for a history and physical examination done in the hospital.

IV. RE-ADMISSIONS

If a patient is re-admitted within a month's time for the same condition, the previous history and physical examination with an interval note will suffice.

V. NURSES' NOTES

The Commission has no requirements concerning nurses' notes. It is the responsibility of the local medical and nursing staffs to develop policies concerning the type and extent of nurses' notes to be kept.

VI. FORMS

1. The Joint Commission on Accreditation of Hospitals recommends no specific medical record forms. Records are evaluated on the basis of content and whatever forms the hospital finds most useful are acceptable. It is common experience that check-off lists do not adequately provide sufficient information to substantiate the diagnosis and treatment.

2. Short Forms

A short form medical record is acceptable in certain treatment and diagnostic cases of a minor nature which require less than 48 hours hospitalization. Short forms may be appropriate for such conditions as tonsillectomies, cystoscopies, lacerations, plaster casts, removal of superficial growths, and accident cases held for observation. The short form should at least include identification data, a description of the patient's condition, pertinent physical findings, an account of the treatment given and any other data necessary to justify the diagnosis and treatment. The record should be signed by the physician.

VII. FILING & MAINTENANCE OF MEDICAL RECORDS

1. Current records should be completed insofar as possible within 24-48 hours.

2. After discharge, records should be completed insofar as possible within 10-15 days.

3. A system of identification and filing to insure the rapid location of a patient's medical record should be maintained. The unit number system is suggested; however, a serial number system or modification of this is acceptable.

4. Records should be indexed according to disease, operation, and physician.

5. If medical records are coded, it is suggested that the Standard Nomenclature be used.

VIII. PRESERVATION OF MEDICAL RECORDS

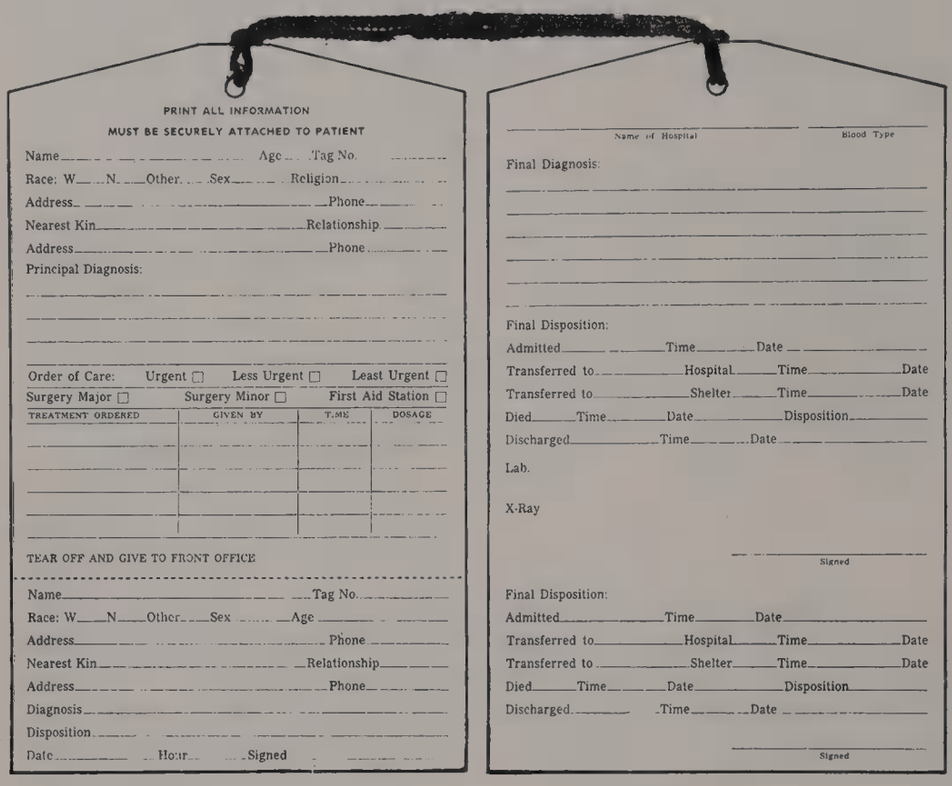
The Joint Commission on Accreditation of Hospitals has no standards governing the preservation of medical records. The length of time a medical record is preserved is a matter which should be determined by the local hospital and local laws.

Methods of preservation by microfilming or other means of storage is a decision for the individual hospital to make.

IX. OWNERSHIP

The medical record is the property of the hospital and is maintained for the benefit of the patient, the physician and the hospital. It is the responsibility of the hospital to safeguard the information on the record against loss, tampering, or use by unauthorized persons. ★

Disaster Patient Identification Tags



PRINT ALL INFORMATION
MUST BE SECURELY ATTACHED TO PATIENT

Name ____ Age ____ Tag No. ____
Race: W ____ N ____ Other ____ Sex ____ Religion ____
Address ____ Phone ____
Nearest Kin ____ Relationship ____
Address ____ Phone ____
Principal Diagnosis:

Order of Care: Urgent ☐ Less Urgent ☐ Least Urgent ☐
Surgery Major ☐ Surgery Minor ☐ First Aid Station ☐

TREATMENT ORDERED	GIVEN BY	TIME	DOSAGE

TEAR OFF AND GIVE TO FRONT OFFICE

Name ____ Tag No. ____
Race: W ____ N ____ Other ____ Sex ____ Age ____
Address ____ Phone ____
Nearest Kin ____ Relationship ____
Address ____ Phone ____
Diagnosis ____
Disposition ____
Date ____ Hour ____ Signed ____

Name of Hospital ____ Blood Type ____

Final Diagnosis:

Final Disposition:
Admitted ____ Time ____ Date ____
Transferred to ____ Hospital ____ Time ____ Date
Transferred to ____ Shelter ____ Time ____ Date
Died ____ Time ____ Date ____ Disposition ____
Discharged ____ Time ____ Date ____
Lab.
X-Ray

Signed

Final Disposition:
Admitted ____ Time ____ Date ____
Transferred to ____ Hospital ____ Time ____ Date
Transferred to ____ Shelter ____ Time ____ Date
Died ____ Time ____ Date ____ Disposition ____
Discharged ____ Time ____ Date ____

Signed

Mississippi Hospital Association Standardizes Emergency Terms

TWO VITAL FEATURES of handling mass victims in catastrophe or disaster incidents are identification of the patient and proper disposition so that the most urgent cases may be cared for first. The institution which has not gone through such an emergency might understandably be unprepared for the influx of 50 to 150 patients. One method of handling these factors of information and direction has been devised by Murray Hill, administrator of the Tunica County Hospital, Tunica, Miss., as an outgrowth of the devastating tornado which roared through his service area last spring.

Shown above is the sample identification tag prepared by Mr. Hill, based on evidence he found necessary to have on hand when treating a large number of patients unexpectedly.

The Mississippi Hospital Association has made supplies of these tags available to its member hospitals in lots of 100 at cost price and urges hospitals in that State to be prepared with a minimum supply of at least 100 tags on hand. This action deserves consideration—and probably emulation—by comparable agencies. ★

SACRED HEART'S POST-OP. —Sr. Theodula

(Concluded from page 63)

tions are checked immediately upon the patient's arrival in the department and every 10 minutes, or at fixed intervals thereafter, until the patient's condition is judged stable. Notations are recorded on the chart as to blood pressure, pulse and respiration, color, skin temperature, presence of drainage, the type and amount, intake and output, and any medications given or special treatments done. All "stat" orders are carried out and intravenous, sub-cutaneous and proctoclysis therapy is started. Sedation is given cautiously. Various respiratory and blood pressure stimulants are kept in the department, as well as such emergency equipment as tracheotomy cut-down and thoracotomy trays. There is an anesthetic machine to give oxygen under positive pressure, a laryngescope with various sized blades and intubation tubes. Plasma, dextron and the intravenous fluids most frequently used are at hand.

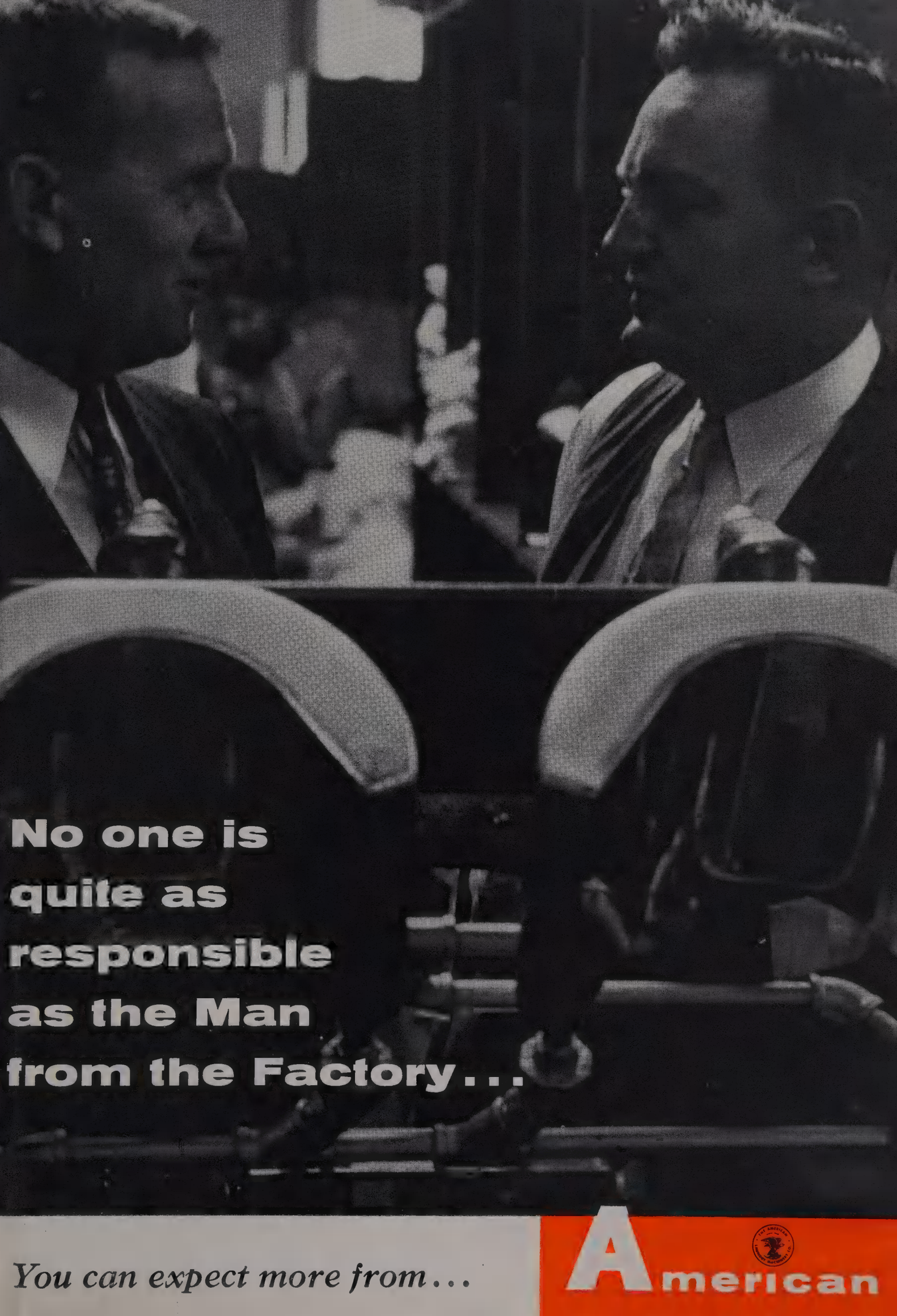
Visitors are not allowed except for gravely ill patients. Clinical units are notified of the patient's arrival in the department and their condition—they, in turn, inform the family. The average length of stay for major cases is three and one-half hours; for minors, about one hour. A critically-ill patient, even though awake, is retained in the department until it closes, thus giving the patient the maximum amount of specialized care. The department is in operation from Monday through Friday, but is closed on holidays.

We have cared for 2,288 patients—354 of whom have had oxygen therapy. The largest number going through the department in one day is 29.

Indubitable Benefits

There are now double the number of patients being returned to the recovery room from the first month of operation. Personnel, doctors and nurses have been fully convinced of the following benefits of the department to the patient:

1. It provides specialized care.
2. It gives centralization of specialized equipment.
3. It saves family anxiety at seeing loved ones going through that recovery period following anesthesia.
4. It allows more time for floor nurses to give patient care. ★



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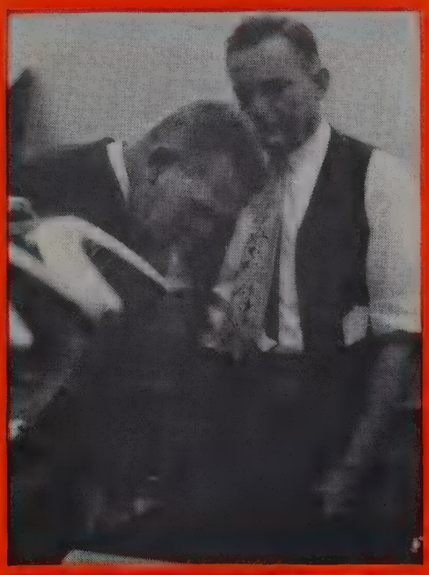

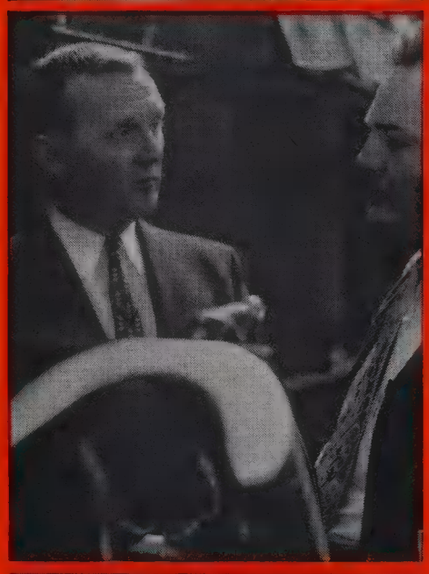

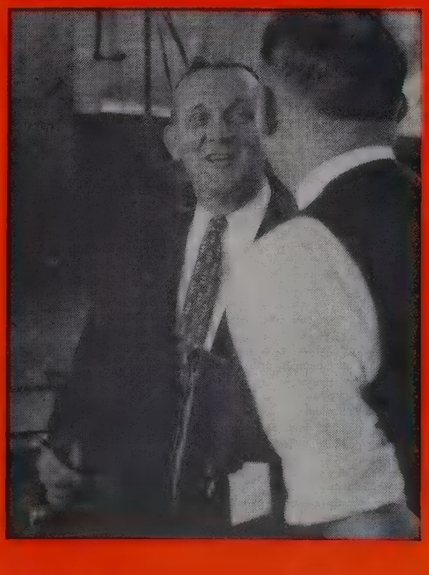

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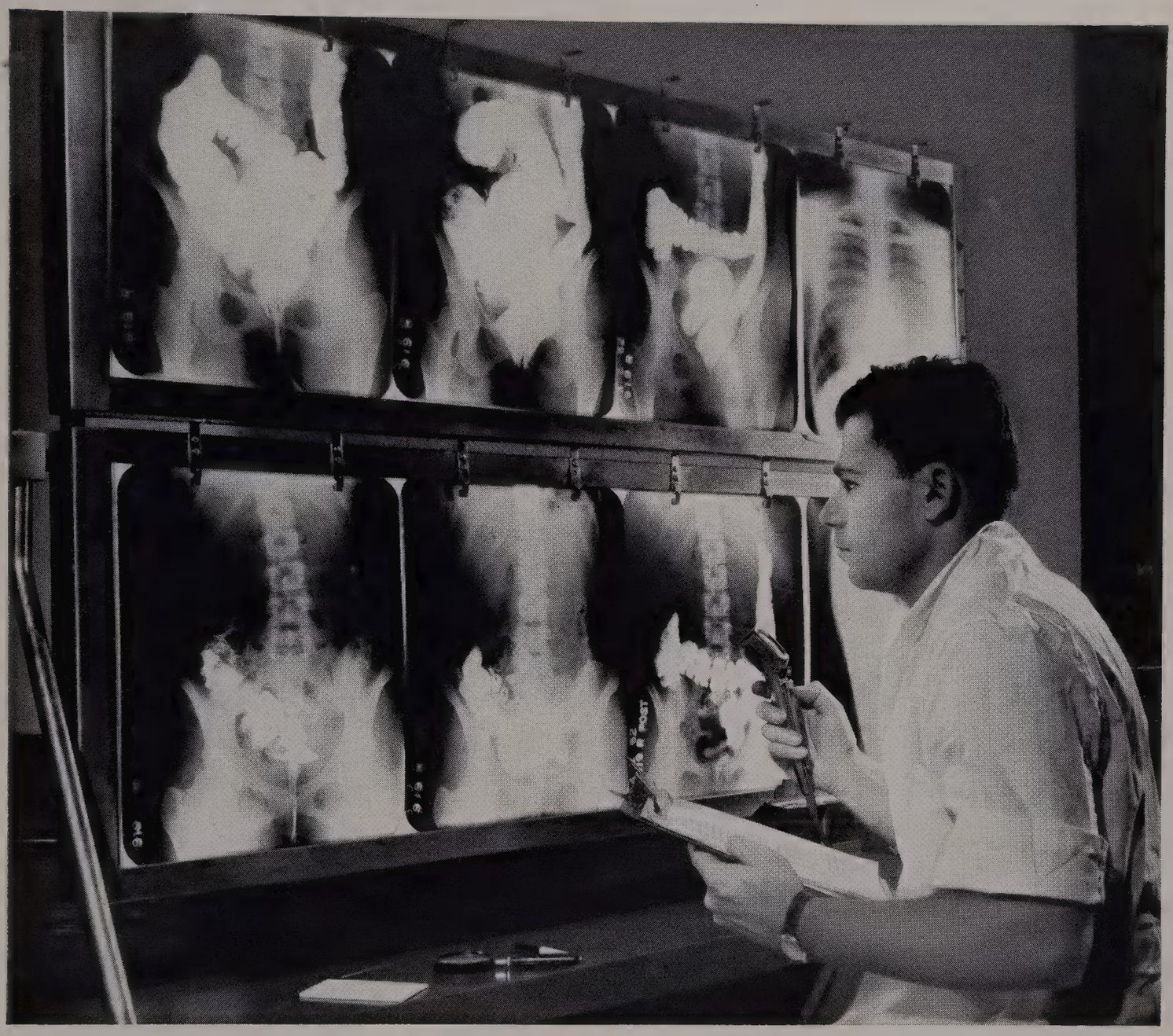

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PHARMACY INTERNSHIPS

New methods replace the older, unstandardized training programs

by SISTER M. BERENICE, S.S.M., St. Mary's Hospital, St. Louis, Mo.

THE CONCEPT OF INTERNSHIP is not new. For years this practical aspect has been considered an essential part of the education of the physician, dentist, dietitian, and other sections of the medical profession. Nurses integrate their class work with bedside clinical instruction. An internship is merely organized, on-the-job education—a practical approach to professional training, as is the laboratory to the study of chemistry.

Pharmacists have been among the first to recognize the importance of this practical aspect of their education. From the beginning State Boards of Pharmacy have required at least one year of practical experience before applicants were eligible for examination. In the past, however, Sister-pharmacists readily recognized that this single year of practical exprience required by State Boards was not sufficient to prepare a Sister to assume the responsibility of administrator of a hospital pharmacy. In those earlier times this practical experience was made dependent upon the actual daily performance of the hospital pharmacy. Usually it required a year or more, and only under exceptional circumstances did it entail less than a year, for a Sister to attain this experience.

However, at least in our hospitals, the Sister was not given the responsibility of a Department of Pharmacy until her Sister-instructor thought her sufficiently prepared to assume it. Thus we see that the Sister's preparation was somewhat unorganized, being geared to fit only the department in which she worked, regardless of the length of time needed for her preparation. This made little difference, since no salary was involved, and the department profited by her services. The Sister, herself, received the necessary thorough preparation before she needed to apply it practically. The Sister-pharmacist long before had become oriented to hospital life and functioning as a member of the particular Religious Congregation she had entered.

Although this preparation was not called an internship, it none the less actually was such, since it adequately prepared the Sister to assume her future responsibilities. The Sister-preceptor also give the student the advantages of all her past experience. We have found that the Sister who has been orientated into the hospital and hospital pharmacy organization and functioning early in her Religious life, can be prepared more quickly to assume the responsibility of head of the pharmacy department than can the graduate of pharmacy who has had no hospital contacts before his graduation.

Now that Catholic hospitals, also, are preparing secular personnel, this former type of preparation is no longer practical. More than that, hospitals have advanced at a pace which does not allow a leisurely preparation even for the Sister-pharmacist. By the former method, there had been established no uniformity of preparation from hospital to hospital.

The secular pharmacist's objective is to prepare himself as quickly as possible, and to become established in his future profession where he will be able to earn the salary to which he is entitled. Therefore, it is expedient that a sound program based upon minimum requirements be established as soon as possible if pharmacy is to maintain recognized status among the medical profession.

You are familiar with the various forms which the internship programs have assumed in the past. We have watched one pattern after another evolve from its predecessor. Today, our plan is becoming more crystallized, and our present concept is to dissociate the internship from academic post-graduate education. The intern in pharmacy may or may not continue his education for the Master's degree. Neither program is contingent upon the other. The intern, however, must be a graduate, registered pharmacist.

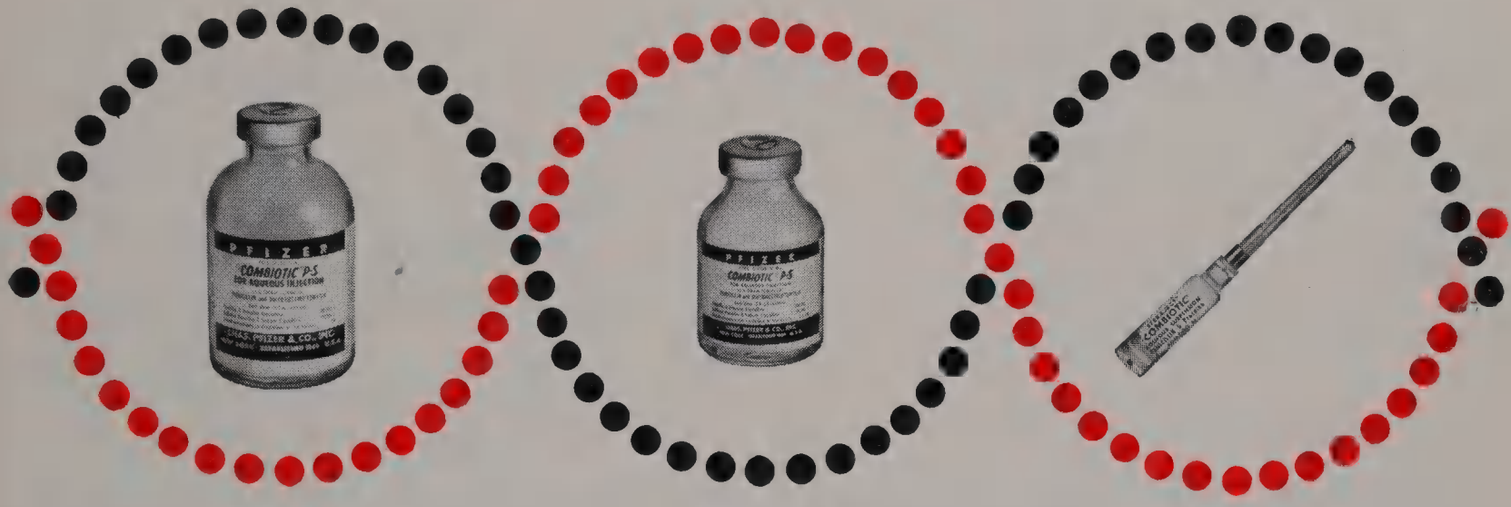
Work is under way by the American Association of Hospital Pharmacists toward evaluation and approval of the internship program and of the hospitals which will qualify to offer it. Although it may seem that work is progressing slowly, this pace is more conducive to the development of a sound program, for haste might make it necessary to retrace our steps. Until this part of the program has been adequately defined, there is not much which can be said about a syllabus for internships.

There are, however, a number of statements which can be made at this time:

1. The internship and the experience needed for State Board examinations cannot be the same. The internship must begin only after the application has become a licensed pharmacist.

2. The internship and the graduate program for the master's degree are no longer considered interdependent. However, the pharmacist who has both the year of graduate work and the internship is much

the economy and convenience of just one vial, just one injection, for combined penicillin-dihydrostreptomycin therapy



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better prepared, and will be a greater asset to the pharmacy department in which he takes his internship.

3. A definite orientation program will be required in order to place the intern in his proper environment.

4. An approved organizational procedure is considered essential.

5. The degree of the quality and the quantity of experience made available to the intern must be approved by the Commission on Internship and Residency Accreditation of the Division of Hospital Pharmacy of the American Pharmaceutical Association and the American Society of Hospital Pharmacists.

6. The number of hours to be spent in the various departments of the pharmacy have been determined.

7. No more than one intern for each full-time pharmacist may be accepted by the hospital.

8. The internship is on a voluntary basis, and is not compulsory.

9. The hospital pharmacy offering internships must conform at least with the requirements of the Minimum Standards.

Even if we could not anticipate a a great number of interns in hospital pharmacy at the beginning of the program, we are confident that the quality of experience if developed according to the plan of the Society will be such as to prepare efficient hospital pharmacy administrators. ★

SOME ASIAN "MINIMUM STANDARDS"

1. A modern physical plant, free from hazards and properly equipped for the comfort and scientific care of the patient.

2. Clearly stated constitution, by-laws, rules and regulations setting forth organization, duties, responsibilities and relations.

3. A carefully selected governing board having complete and supreme authority for the management of the institution.

4. A competent, well-trained executive officer or administrator with authority and responsibility to carry out the policies of the institution as authorized by the governing board.

5. An adequate number of efficient personnel, properly organized and under competent supervision.

6. An organized medical staff of ethical, competent physicians for the efficient care of the patients and for carrying out the professional policies of the hospital, subject to the approval of the governing board.

7. Adequate diagnostic and therapeutic facilities with efficient technical service under competent medical supervision.

8. Accurate and complete medical records, promptly written and filed in an accessible manner so as to be available for study, reference, follow-up and research.

9. Group conferences of the administrative staff and of the medical staff to review regularly and thoroughly their respective activities in order to keep the service and the scientific work on the highest plane of efficiency.

10. A humanitarian attitude in which the best care of the patient is always the primary consideration.

Reprinted from *The Catholic Hospital* [Sept.-Dec. 1955], official organ of The Catholic Hospital Association —India, Pakistan, Burma, Ceylon; edited and published by Sister M. Clare, Holy Family Hospital, New Delhi.

by GEORGE E. REED • Washington, D.C.

THE PRESIDENT'S State of the Union message to Congress [January 5, 1956] in many respects merely pointed out areas where legislation is necessary. Within a short time, detailed proposals implementing the State of the Union message will be sent to Congress. One, for instance, will be sent on the subject of health and hospitals. With respect to this subject, the president stated:

"The Nation has made dramatic progress in conquering disease—progress of profound human significance which can be greatly accelerated by an intensive effort in medical research."

He thereupon recommended a well-balanced program of research (including basic research) for the purpose of preventing and relieving suffering, and for prolonged life. No figures were given, but he recommended a substantial increase in Federal funds for the support of research programs. The president said:

"As an integral part of this effort I shall recommend a new plan to aid construction of non-Federal medical research and teaching facilities and to help provide more adequate support for the training of medical research manpower."

This phase of the president's program is becoming increasingly popular and there is strong reason to believe that this session of the Congress will enact legislation implementing this recommendation. Continuing, the president stated:

"We must aid in cushioning the heavy and rising cost of illness and hospitalization. Provision should be made by Federal re-insurance or otherwise to foster extension of voluntary health insurance coverage to many more persons, especially older persons and those in rural areas. Plans should be evolved to improve protection against the cost of prolonged or severe illness."

These recommendations were forecast several weeks ago by the new Secretary of Health, Education and Welfare, Marion B. Folsom. For some time before Mr. Folsom entered Government service, he had evidenced a strong interest in health insurance. It is therefore to be expected that he will carry on vigorously a program designed to increase Government assistance, particularly to those who find it difficult to carry adequate medical and hospitalization insurance policies. A short time ago Mr. Folsom indicated that we are ready for a wide extension of insurance plans. He identified three areas with which the Government should be particularly concerned:

The first is catastrophic illness. The secretary of the Department of Health, Education and Welfare indicated that in the past we have concentrated too much on short-term illnesses. He is of the opinion that it is the long-term illnesses which have most profound social effect upon the country. The administration program which will be announced in the near future is expected to cope with this in detail.

The second problem, in the opinion of the secretary, is to extend coverage to the aged. A large number of the voluntary health insurance programs do not cover those over sixty-five. Undoubtedly, the new health proposals will be aimed at the group 65 or over. Mr. Folsom feels that such a program ultimately would result in taking many elderly people off relief and old age assistance.

The third field mentioned by Mr. Folsom, which is likewise reflected in the president's message, is extension of health insurance to people residing in rural communities. For the most part, health insurance programs operate in urban areas.

Mr. Folsom stated: "We are working in all of these areas and we hope to come out with some sort of a program for re-insurance or pooling of risk which would encourage insurance companies to come out with different type policies and to expand their coverage."

It was announced recently that Dr. Lowell T. Coggeshall was nominated as special assistant for health in the Department of Health, Education and Welfare. In his press conference in December, Secretary Folsom stated that Dr. Coggeshall is "perhaps the best qualified man for the job in the United States." Dr. Coggeshall is dean of the Division of Biological Sciences at the University of Chicago.

Another interesting development in the field of health is the report by a special Senate Sub-committee headed by Senator John J. Sparkman. It stated that health insurance for families is necessary and that where people are not in a position to take such insurance the Government should contribute all or part of the cost. All these developments indicate that this session of Congress will see strong emphasis on some participation by the Government in the field of health insurance. Both parties seem eager to develop a program in this field.

Note on the Ford Grants

The generous grants made by the Ford Foundation to non-profit hospitals are currently in the stage of implementation. One of the requirements necessary for participation in this grant is evidence of tax-exempt status. By this time most of the hospitals have received a communication on this point by The Catholic Hospital Association. In the event that this has not been received, it can be authoritatively stated that it is sufficient for hospitals, in filling out the questionnaire sent by the Ford Foundation, to indicate the page on which their hospital appears in *The Official Catholic Directory,* which in turn is the subject of a tax-exempt "group ruling" which was extended to the National Catholic Welfare Conference for the benefit of the Religious, charitable and educational organizations listed therein.

Education and the Dietitian

DETAILING REASONS WHY THE END OF FORMAL OR IN-SERVICE TRAINING IS A "COMMENCEMENT"

by SISTER MARY CAROLA, S.S.M., Director of the Department of Dietetics ■ St. Louis University

THE ROAD TO EDUCATION often is paved with sacrifice. It takes great determination to spend four or more years in college to get a degree in preparation for entering a profession or business. This long preparation for a college degree can be compared to the digging necessary in order to lay a foundation for a building, but if the preparation for erecting a building ceased with the foundation, there would never be an edifice. If learning were to stop with a college degree, would any professional person be able to contribute on a continuing basis to his field? For the dietitian, as for other professionals, the desire and the need to learn must continue beyond the years of internship, in order to meet the changing demands of a dynamic society.

Today we read and hear much about in-service training, staff education or human relations programs—all with the purpose of improving the individual. As one authority stated, "First, it is essential that top level administrative personnel actively participate in the training, in order to insure co-operative participation and complete acceptance of the program by all levels of supervisory personnel."[1] The dietitian, as one of the top level personnel in her organization and as a professional person, has the responsibility to improve herself and also those with whom she works and those whom she supervises. The American Dietetic Association has compiled self-appraisal sheets to enable the dietitian to ascertain her own strengths and weaknesses.

The dietitian has pursued prolonged intellectual training to prepare her for her work. In her course of studies she has acquired knowledge that will enable her to give a specialized service to society. She is a member of national, state, and local professional associations that are ready to aid her to advance intellectually by their publications and meetings. In order to give the best possible service to humanity, the dietitian must continue to be a student all her life, and keep abreast with all advances in the field of dietetics.

The contribution of the dietitian touches other professional fields, too, particularly medicine, dentistry, and education. Society at large recognizes the value of this professional person. This should challenge the dietitian to develop professionally, that is, to broaden her knowledge by encompassing more of literature and history, sociology and economics.

The dietitian in her administrative capacity directs one of the major departments in the organization. She is in a position to speed the progress of nutrition. A good cook or chef can prepare foods that will attract the eye, please the palate and satisfy hunger, but do nutritional harm because the meal is inappropriately planned or poorly balanced from a nutritional standpoint.

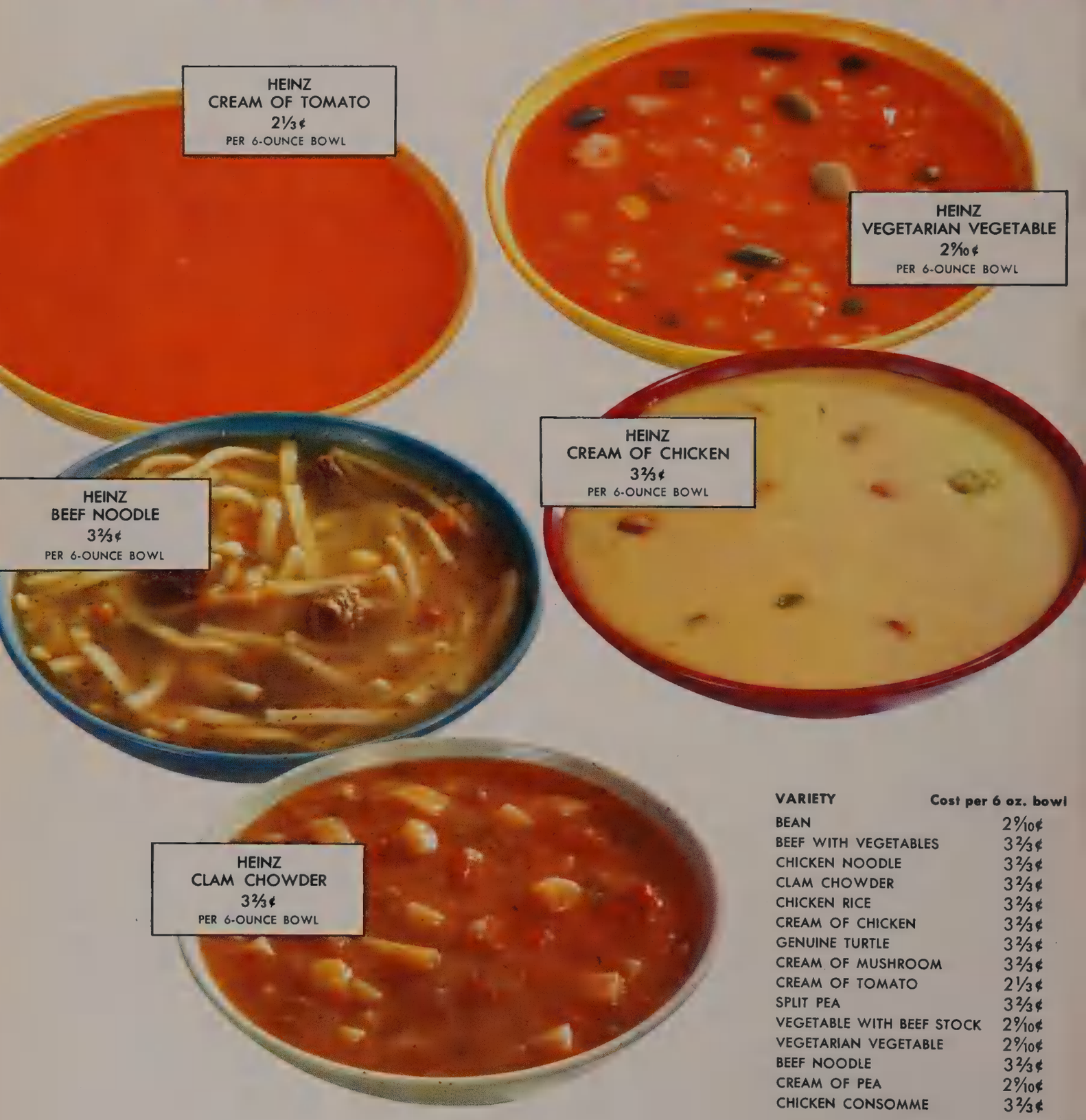
One of the dietitian's major concerns in planning menus is the *food value* of the meal. But not only is the dietitian equipped by knowledge and training to plan nutritious, adequate menus; she also knows how to organize and manage the dietary department. In some instances, the dietitian's function is limited to that of planning and administering modified diets. Where this holds true, the organization is not making use of all the dietitian's abilities. A well-run hospital provides proper nourishment for its personnel as well as for its patients. In larger hospitals, the administrative dietitian is responsible for the organization and general operation of the department.

Sometimes the function of planning and equipping the dietary department is given to one not fully prepared to cope with the task, due to the fact that the salary offered will not attract the experienced dietitian. Sometimes, too, the young dietitian who has just finished an internship accepts a position that should be filled by someone more experienced. In the latter case, the administrator can be of great help to the young dietitian with his or her knowledge and experience by giving her guidance in personnel management, budgeting and many other functions common to the management of any department.

(Continued on page 80)

[1]Walter J. Coville, "Psychology Conferences Re-make Departments," HOSPITAL PROGRESS, XXXVI, No. 7 (July, 1955) p. 84.

COMPARE AT YOUR PRESENT



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BEEF WITH VEGETABLES	3⅓¢
CHICKEN NOODLE	3⅓¢
CLAM CHOWDER	3⅓¢
CHICKEN RICE	3⅓¢
CREAM OF CHICKEN	3⅓¢
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DIETARY

—Sr. Mary Carola

(Continued from page 77)

The educational function of the dietitian not only includes the teaching of the dietetic intern and student nurse, but extends to medical and dental students, all personnel of the hospital (including doctors and nurses), patients, and the public at large. The dietitian is in a position to offer to all the workers in the hospital, non-professional as well as professional, guidance in health preservation. The dietitian has unlimited opportunities for contributing to health education. In the food clinic, the dietitian has many opportunities to teach the public preventive measures against illness. As in other sciences, progress is made in nutrition through research. It is often necessary to correlate the efforts of the dietitian, the clinician and the laboratory worker before a research project can be completed.

The American Dietetic Association is interested in staff education to the extent that it is organizing a project to determine methods of carrying out such a program. In a hospital, there may be only one dietitian, or as many as ten or more.

The dietitian should be looked to as an authority in her field, but unless she keeps up with all the new developments in nutrition, research, administration, personnel management, and other areas, she cannot be considered so. How is she going to keep herself informed? She will find much help in her professional journal. Does she read and study it? What about the reference library in her own institution? Does she avail herself of this wealth of knowledge? Salesmen and other company representatives are able to furnish her with valuable information. Could she be helped through a workshop conducted by mail? Would it be possible for her to attend dietitians' meetings in the area? Such meetings are held in all large cities, usually on a set day of the month, in the evening.

What can the Sister-dietitian do, since she usually does not have permission to travel around the city in the evening? She, likewise, has the responsibility of keeping informed on new developments, so how can she be helped? Perhaps the Sisters could have a meeting in the afternoon, to talk over their problems or to hear guest speakers. Would this help the Sister-dietitian, when she is the only dietitian in her hospital?

The administrators of hospitals and other institutions should encourage their dietitians to attend meetings of national, state and local associations because such meetings are planned and programmed to keep the dietitian well informed concerning new developments and trends in the ever-changing field of dietetics.

Staff meetings, held regularly, are a means to keep the dietitian informed of recent trends and developments. One of the purposes of a staff meeting is to develop group enthusiasm. Staff meetings should never be a drudgery; they ought to be stimulating and motivating. To accomplish this, they should be well-planned and premeditated before the day on which the meeting is scheduled.

Everyone should be given the opportunity to talk. With a large staff, there are many opportunities to share ideas. When minds meet, much can be achieved. Often it is the ideas of one staffer which motivate other staff members to start or to carry out a project. Everyone has problems to solve. Others may have had the same problem that you are having, and have found some means to solve it, which they will share. The purpose of the staff meeting is not only to get, but to give, information. Often young staff members will come forth with a solution which an older one may not have realized. Young members should be encouraged to take active part in the meeting. Give them a chance to present information that may be helpful to others. More experienced staff members can be extremely helpful in giving the younger ones guidance when necessary. Interchange of opinion on ways to solve a problem can develop into a vital, helpful session.

At a recent national dietetic meeting, the director of a large dietary department related that at a staff meeting where food standards were to be discussed, one whole hour was devoted to baked potatoes. Anyone who is not familiar with the problems of producing a good baked potato may wonder how so-called intelligent people could possible devote 60 minutes to this apparently simple subject. Much enters into producing a good baked potato and then delivering the finished product to the patients or personnel in a hospital. Any number of questions are pertinent. What variety of potato is best for baking? How can it be transferred to the point of serving without its becoming soggy? How can it be kept hot? How long can the potato remain on the steam table and still be palatable?

It is the dietitian's responsibility to encourage good food standards, so, why

(Concluded on page 82)

Three Institutes Announced for Dietitians

FONTBONNE COLLEGE, St. Louis, Mo., in co-operation with The Catholic Hospital Association, will inaugurate a series of three summer Institutes for hospital food supervisors. These Institutes, the first of which is scheduled for June 18 to July 6, 1956, are planned for Sisters who have not been trained as dietitians and yet are fulfilling the duties and carrying those responsibilities.

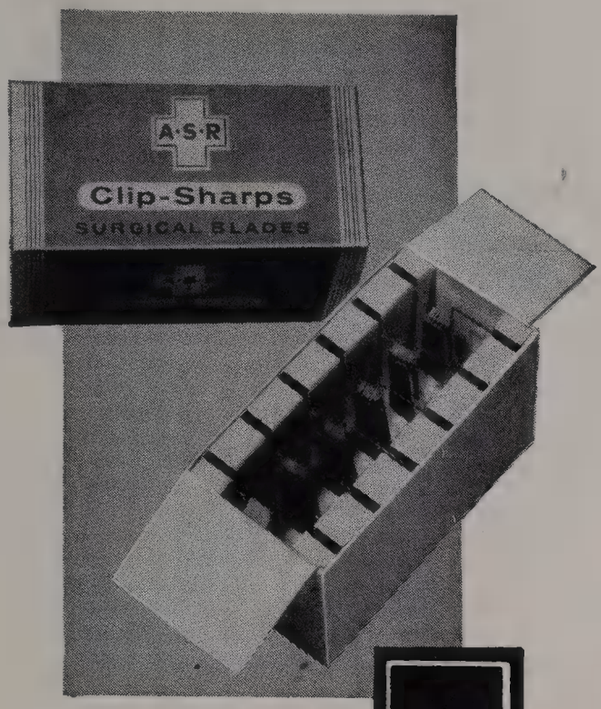
The Institutes will be conducted by outstanding authorities in the following phases of dietary administration:

For the summer of 1956—Personnel Management with Laboratory Experience; Menu Planning; Demonstrations on Modern Methods in Institutional Food Service; and Sanitation.

For the summer of 1957—Nutrition; Diet Therapy; Purchasing and Food Cost Control; and Portion Control.

For the summer of 1958—Organization and Management; Equipment and Layout; Recipe Development and Standardization; and Administrative Responsibilities.

The Institutes will be in session for three weeks for three consecutive summers. Those attending the three Institutes will be awarded a certificate attesting completion of the course. ★



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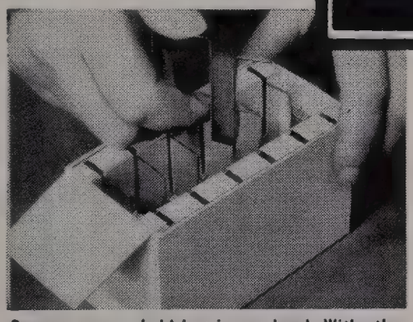
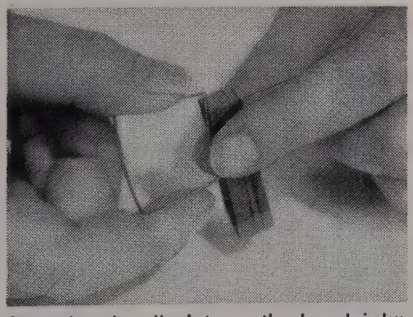
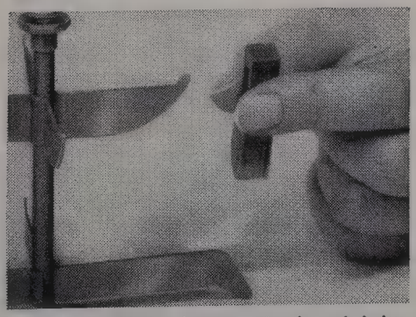


Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



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DIETARY

—Sr. Mary Carola

(Concluded from page 80)

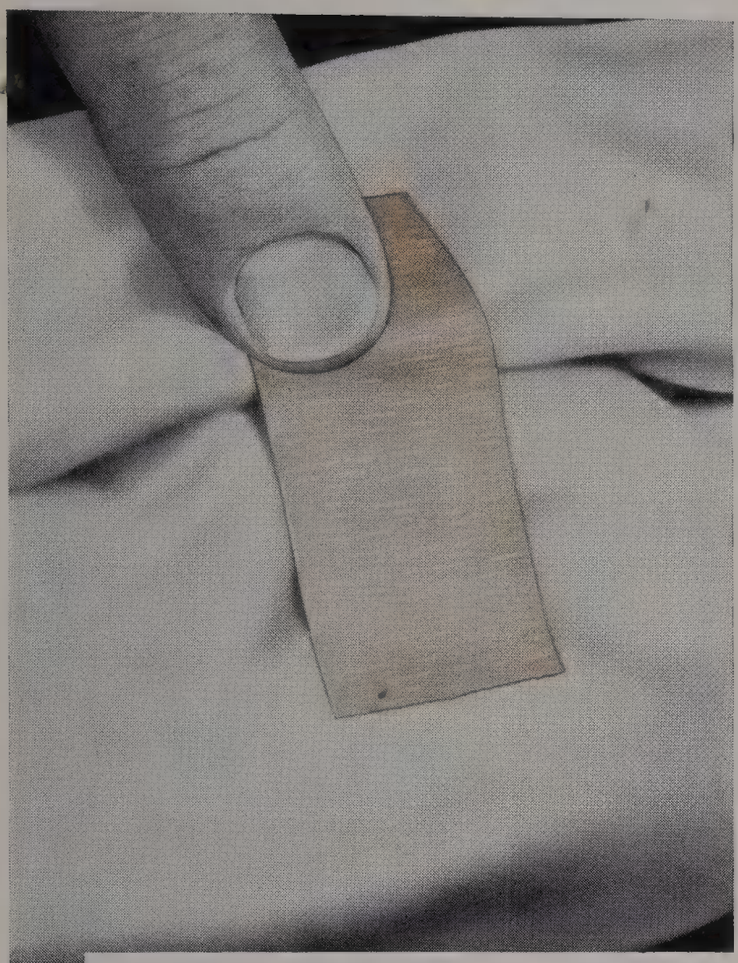
not bring your problems and achievements before the group? It is a problem to produce the exact number of servings needed. There is the problem of not producing enough or producing too much, and then how to use the left-overs. There is the problem, too, of standardization. Someone may be present in the group who has solved this quandry (at least to some extent). Why not let others hear about your experiences, so they can be helped? There is that vexatious question of the employee who is an excellent worker, but habitually comes late. What measures should be taken? Some experienced person in the group may be able to give competent advice on how to deal with the tardy employee.

Bring in the dietitian from the small hospital. She may possess a wealth of information that she is eager to share with others. It is possible that the dietitian in a small community, or the only dietitian in a larger institution, is better informed on new developments in nutrition and administration than the dietitian who is one of many personnel in a larger organization. If the dietitian does not avail herself of the existing opportunities to improve in her field of work, much of her knowledge will soon be outdated.

Sisters' hospitals have the reputation of being clean. Does the dietitian working side by side with the Sister-dietitian know how this cleanliness is accomplished? There are those gleaming walls. Who washes the walls, and how often? What compound is used to clean them? Does the dietitian beside you know the answers, so she can make use of this information when she leaves you and goes out on her own? Why is one dishwashing compound used, in preference to another? Does she know that the exterminator makes his periodic visit to the department to rid it of insect pests? "How to keep things in order" would be a stimulating topic for a meeting.

Most dietitians find some time to read, but it is impossible to crowd all the excellent articles published into an already overburdened schedule. Why not assign dietary staff members some of these articles for oral review at a meeting, so that at least some of this valuable information is brought before the entire staff. It is not possible for all faculty members to attend meetings held in other cities. Members who do attend should give a report on the material presented by the speakers, so that the whole staff in the department can benefit. There are many films available which are educational and very useful for staff meetings. These are only a few suggestions that could supply much food for thought and for staff meetings.

Just as the Religious is bound to strive for perfection, so too is he or she bound to continue to improve as a professional person. The novitiate for Religious presents the principles of a religious life, lays the foundation for living such a life, and inculcates a striving for perfection. This striving for perfection does not cease with the termination of the novitiate—it is only the beginning, and must continue. So, too, with the education of a professional person, lay or Religious. The obligation or responsibility to continue one's education does not cease with a degree or the completion of an internship—it is only the beginning of a further development into a fine professional person who can contribute much to society. ★



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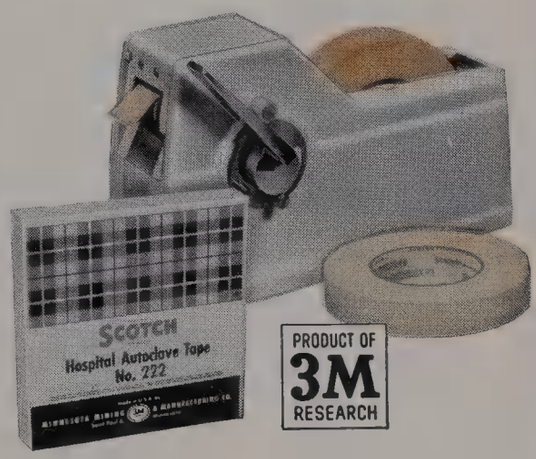
No danger that sunlight or radiator heat will bring out the distinctive stripes on this foolproof tape. When you see them on an autoclave pack (and they can be seen clear across a room) you're sure that pack has been through the autoclave. *This is not positive proof of sterility, of course—nothing on the outside of a bundle can prove that.*

Seals packs firmly in half the time required for pinning, tying, or tucking! "SCOTCH" Hospital Autoclave Tape No. 222 holds in high steam temperatures, leaves no stains or gummy residue, can be written on with pencil or ink.



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Determining Work Load Standards

by ANNE VESTAL • St. Louis, Mo.

DID YOU HAVE TIME to order your copy of Standard Cleaning Methods? Better do it soon, as we shall have need of it next month.

This time we are going to begin consideration of the problem you have indicated leads all the rest in your work as hospital housekeeepers: determining a fair work load for each housekeeping department employee.

In industry, it is simple enough to make a work load determination since the factors to be considered are standard or are susceptible to standardization. In hospitals we deal with non-standard human beings (the sick, suffering a wide variety of ailments), develop a non-standard product (health), in non-standard work areas (offices, clinics, operating rooms, patient rooms) each of which is furnished with non-standard equipment, furnishings, wall and floor finishes. There are innumerable variables not only in each hospital, but areas within any given hospital, and even day-by-day variables within each area.

You already know these things; I repeat them only so you may be certain that I am aware of your total problem, and further so you will be inclined to accept the somewhat lengthy and detailed plan I shall develop for and with you on these pages.

Believe me, this means work; there are no short cuts. But every time these methods have been followed, the results have been worthwhile. In some instances you will find you must add to your staff; in many happy cases, you can make adjustments enabling you to cut your staff, or improve your housekeeping product (sanitary, attractive, orderly premises) with no increase in budget. In all cases, you should be satisfied that you have found a measure of an hour's work for each hour of salary you are paying.

Before you start on the five steps leading to a conclusion on your work load determination program, you must establish some facts, and make some preliminary evaluations. Ask yourself these questions:

Dietary Quiz Session

1. What do you mean by "clean"? How clean is "clean"? What profit is there in scouring a surface so it is free of soil, but the surface marred or even destroyed? (Good cleaning methods and suitable cleaning materials, are of prime importance).
2. Under what conditions are you doing your cleaning? Are you in a dusty, smoky area or in a clean suburban situation? Are you using care (and rubber or fibre mats at doorways) to prevent soil from entering your building? What is the state of repair of the surfaces you are cleaning? Are you doing your work at a time when your area is highly obstructed by wheeled equipment and lots of traffic?
3. Have you enough equipment so no time is lost in "borrowing" from distant stations, or waiting until equipment is free for use? Is equipment stored close to the place where it is to be used? Is equipment in good repair?
4. What caliber of personnel are you using in your department? (Senile, infirm, sub-standard personnel can produce only sub-standard work, and in inadequate quantity!) Do you exercise the proper quantity and quality of supervision? Have you done all you can to up-grade yourself as a supervisor?

Have you thought these questions out? Discouraged? Don't be; you can't afford to let down now. The work ahead can be fun—profitable fun—since the harder you work and plan now, the greater your accomplishment and satisfaction for a long, long, time to come.

Ready to go? There are five major steps to be taken in reaching a conclusion about what constitutes an equitable work load. Each step must be developed fully before the next one is attempted.

It is not possible, of course, for you to accept in their entirety those conclusions or schedules arrived at through studies in institutions other than your own, because of varying conditions in those places of which you may not be

Note to Dietitians

It is earnestly hoped that readers of this department will exhibit the willingness—and find the time—to co-operate in the project proposed by Mrs. Vestal at the end of the present article. The compilation of lists of the duties performed by each member of the Dietary Department will prove an enlightening task. The value of your work will be augmented mightily if you will share with others your discoveries concerning job allocations, while the Central Office acts as a clearing house for their collection and evaluation.

Here is a research function which it is your duty to support. Let us have your co-operation.

The Editors

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Wescodyne — ***NONSELECTIVE KILL*** Exceptionally wide range effectiveness against: bacteria, viruses, fungi, yeasts and other pathogens.

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Wescodyne — ***NONSTAINING, NONIRRITATING, NONTOXIC*** No skin irritation. No staining of hands, equipment, or surfaces. Absolutely safe when used as directed.

Wescodyne — ***COSTS LESS*** It's inexpensive because so little does so much. The usual recommended dilution of 3 oz. to 5 gallons of water (75 ppm available iodine) costs less than 2¢ per gallon.

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HOUSEKEEPING

—Vestal

(Concluded from page 84)

aware. You must tailor your own plan.

The five steps follow:

1. List the duties assigned to housekeeping in your hospital.
2. Make a standard work procedure for each task you have listed.
3. Through time studies, arrive at a standard time for completion of each task.
4. Determine the frequency of repetition of each task. Make a work book in accordance with an illustration which will appear in HOSPITAL PROGRESS.
5. Combine tasks into jobs. From the combinations you develop work schedules.

This is the way to do Step 1: Make a list of all duties performed by housekeeping employees. In small hospitals, especially, housekeeping personnel perform functions which in larger hospitals might be assigned to dietary aides, nurses aides, etc. At this time, let us not argue the pro's and con's of such assignments nor attempt to change them Let us accept such work assignments as Administration, necessity, or other factors have dictated in your hospital. Simply list each and every task performed by a maid or porter, like this:

Maid	*Porter*
Cleans bathrooms (here state number and areas)	Washes windows (how many in hospital)
Cleans metal	Cleans screens
Cleans porcelain	Dusts venetian blinds
Scrubs floor	Washes venetian blinds
Replenishes supply of tissue	Dusts halls
Cleans patient room (how many rooms in hospital?)	Mops halls
Dusts sills	Waxes halls
Damp wipes bed	Buffs halls
dresser	Moves furniture, etc. etc.
overbed table	
bedside cabinet	
lounge chair	
side chair	
foot stool	
Empties waste basket	
ash trays	
Dusts lamps	
Makes empty beds (average check-outs per day)	
Scours drinking fountains (how many)	
Cleans sand urns	
Washes water pitchers	
Collects diet trays, etc. etc.	

Your lists may be longer or shorter, or may include entirely different duties.

In order to make your list completely inclusive, ask your maids and porters to give you a list of their duties. Check with everyone who directs, guides, or comes into other contact with you maids and porters. Staff nurses can be of great help in making these lists, especially if yours is a decentralized housekeeping set-up, with no one person in charge of all maid and porter work. You will find a great variation of duties in different areas of small hospitals where only a limited number of people are available to do the many tasks required in all hospitals, large or small.

When you have made your lists, will you send me a copy, please? It need not be typewritten or fancy—even scratch paper will do. I think it would be instructive to see just how many kinds of work are assigned to housekeeping personnel, don't you? Send your list to me in care of HOSPITAL PROGRESS.

Watch for Step 2 next month. Be seeing you then! ★

New...

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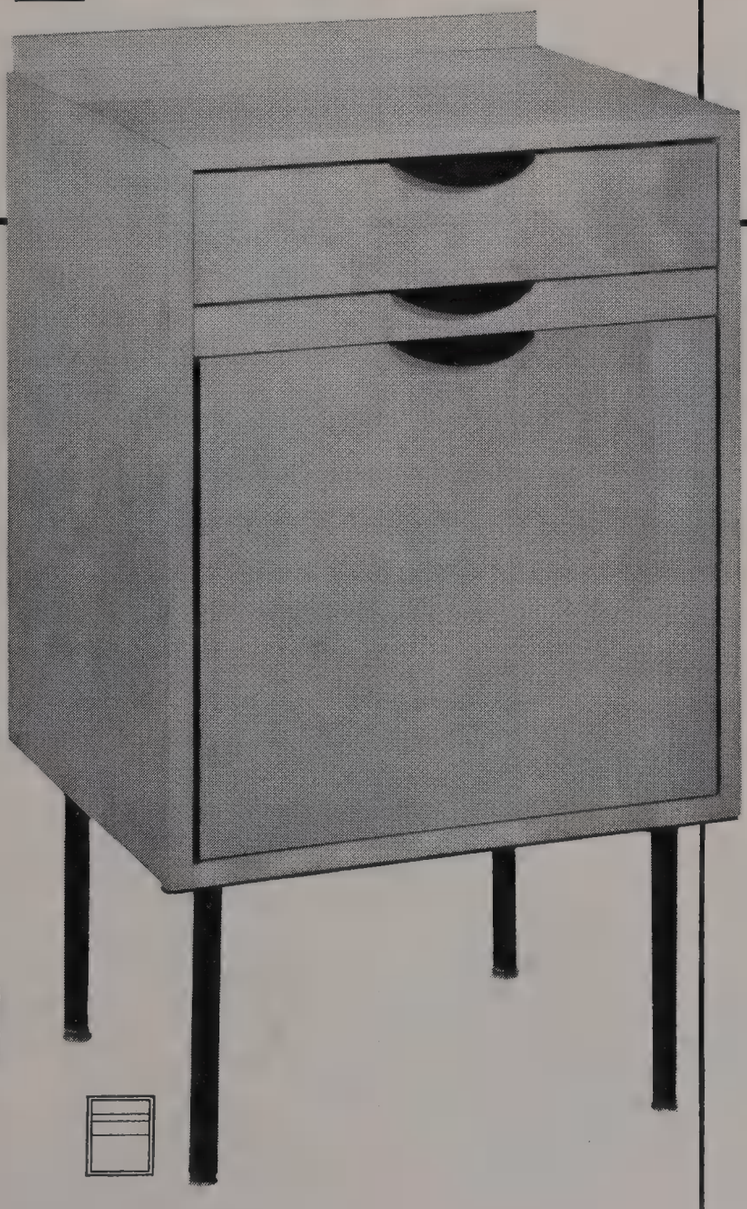

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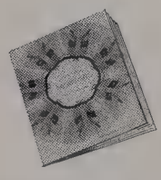

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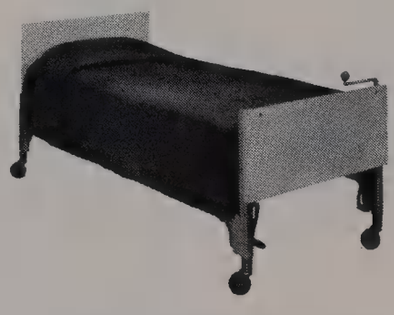


TYPICAL of the KALEIDOSCOPE grouping is this **CARROM - 2 - HEIGHT** Bed . . . electric or manual. The grouping also includes easy chairs, side chairs, overbed tables and flower tables.

NEWS AND NOTES

■ Solemn requiem Mass was celebrated in Mount St. Vincent's Chapel, Seattle, Wash., for Mother Petronilla. During her 53 years in religious life, she served in hospital administration work. From 1931 to 1947, Mother Petronilla was Provincial Superior of the Sacred Heart Province and she was a former superior of St. Vincent Hospital, Portland, Ore., and Sacred Heart Hospital, Spokane. Her last assignment was at St. Joseph Hospital, Burbank, Calif., where she served as purchasing agent.

■ The Utah Chapter of the American Association of Hospital Accountants has elected Sister M. Alma Eugene, accountant of Holy Cross Hospital, Salt Lake City, as its president.

■ Mr. Gerald J. Malloy, formerly of Milwaukee and for the past year administrative assistant at Touro Infirmary, New Orleans, La., has been appointed assistant administrator of St. John's Hospital, St. Louis, Mo. The hospital, a 425-bed institution is operated by the Sisters of Mercy of the St. Louis Province, who are currently celebrating their Centennial Year.

■ Ownership of the Otis General Hospital, East Cambridge, Mass., has been transferred to The Little Company of Mary.

■ The Daughters of Charity of St. Vincent de Paul observed their 100th anniversary of service to Southern California at a Solemn Mass of Thanksgiving in St. Vincent Church, Los Angeles. Arriving in California in 1856, six Sisters established the first day school, orphanage and hospital in Los Angeles and the first English-speaking school in Santa Barbara.

■ A physical therapy department with the latest equipment is now in operation at St. Joseph's Hospital, Houston, Tex. Another major development at the hospital is the installation of high pressure, single-duct air-conditioning in the maternity building.

■ Construction plans for a $750,000 service facilities wing at St. Joseph's Hospital, Asheville, N.C., have been announced. The new wing will replace and greatly enlarge the hospital's present surgical and obstetrical facilities. New and vacated space will add 40 beds, for a total of 140.

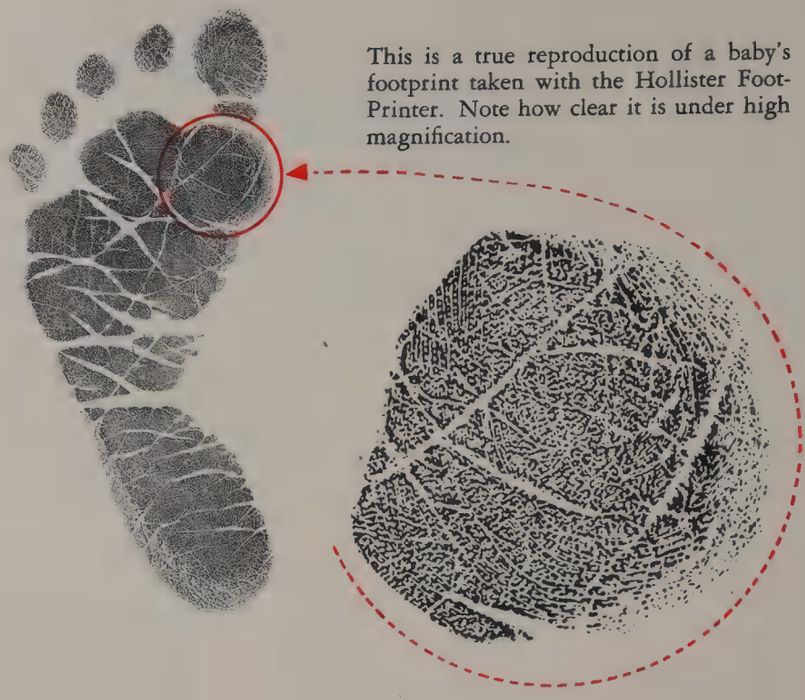
■ The Most Rev. George J. Rehring, Bishop of Toledo, presided at the ceremonies for the consecration of the altar and dedication of the new chapel at St. Rita's Hospital, Lima, Ohio. The chapel is located on the first floor of an addition to the hospital built above the emergency—out-patient section. The second floor of the addition provides an additional 12 to 14 patients' beds, as well as auxilliary nurses' stations and service stations. Work has been started on remodeling the space occupied by the former chapel for use by the hospital's business offices.

■ Commemorating 80 years of service in Salt Lake City, Holy Cross Hospital held a dinner meeting for the medical staff. Honored guests of the evening were physicians who have been members of the staff for more than 30 years.

"My word... such perfect Footprints!"

To see how these footprints got so perfect . . . turn page

NOW... perfect footprints for your protection!



This is a true reproduction of a baby's footprint taken with the Hollister Foot-Printer. Note how clear it is under high magnification.

THE primary purpose of taking new-born footprints is to establish legal, lifetime identification, which protects the hospital by providing evidence of each new-born's identity. As the FBI has stated "The purpose of taking footprints is to provide a permanent record of individuality so that in the event a question should arise later as to the identity of the child and its mother, conclusive proof of its identity can be offered. The footprints of the infant, therefore, should be taken at birth."* Yet, even today, hospitals are taking thousands of baby footprints that have little, if any, identification value. This is because the old-fashioned methods that were originally designed to take prints of thick, coarse adult skin are being used to take prints of soft, delicate baby skin. This, of course, results in footprints that are heavy, filled-in blobs of ink, unsuitable for identification. And that is why the revolutionary Hollister FootPrinter was developed.

Why is the new Hollister FootPrinter revolutionary?

First— it embodies an important, unique principle of taking prints — it uses a special dry plate instead of a wet and soppy ink pad or messy glass and ink roller. Instead of a thick coating of ink this new dry plate puts a light, very even film of color on the infant's microscopically fine skin. Then, when the print is taken, each tiny whorl and line can be clearly and perfectly reproduced.

Second–research proved that in order to get the perfect print made possible by the new dry plate method, the print had to be placed on paper that is smoother than the baby's fine skin. Ordinary paper isn't smooth enough to print an exact reproduction of the baby's fine skin. For this reason, prints taken with the Hollister FootPrinter are placed on glossy Kromekote paper, which furnishes lifetime identification for permanent hospital records. And further, Hollister-taken prints on Kromekote paper can be easily microfilmed because each little whorl and line is so clearly distinct.

Beyond this, with the Hollister FootPrinter nurses can take prints in seconds — instead of minutes. They do it by merely pressing the newborn's foot lightly against the sensitive dry plate — then taking the print. And that's all! It does away with the mess and bother of smeary tubes and messy pads of ink. And the baby's foot stays practically clean, as do the busy nurse's hands. There's no difficult wash-up of baby's foot. The dry plate fits snugly into a sturdy plastic case and will take 150 prints. Then, when the plate's color is used up, it can be discarded and replaced with a fresh plate.

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*FBI Law Enforcement Bulletin, January, 1945

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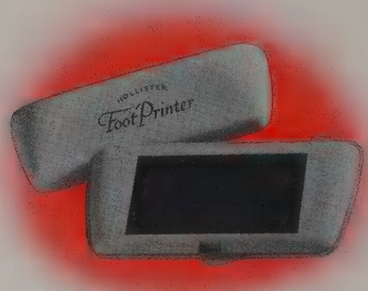

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Achieving Planned Public Relations

by SISTER M. ADELE, O.S.F., Assistant Administrator
St. Francis General Hospital & Rehabilitation Institute, Pittsburgh, Penn.

WHEN WE ATTEMPT to visualize the steps required to organize a public relations program, we find the atmosphere pervaded with activities bearing directly on what we are trying to do. We cannot begin to build on a "vacant lot," as when we build a new wing. Any hospital which has been in existence for any length of time has already established public relations. The hospital is dynamic and will not stand still while we set up our plans. We must remember, however, that we will never find the ultimate in public relations or reach perfection in this field. Regardless of the work the hospital has accomplished and the success it has attained in the past, much more can be done to create better public relations.

Many hospitals become vitally concerned about the status of their public relations at a time of crisis (generally when funds are needed in an expansion program). Since we are engaged in a campaign to raise funds for a new building project at St. Francis General in Pittsburgh, I thought the best way to present concretely "How to Build an Organization Necessary to Foster Good Public Relations," would be to tell simply what we are doing at the present time. I know our effort is based on sound principles because the men who are conducting the campaign are associated with a nationally-renowned fund-raising company, and I know from my conversation with other administrators that what we are doing is typical of what has been done in other hospitals.

Several years ago, our board of managers, the administration, the medical staff, hospital personnel, nurses' alumnae and women's auxiliary began asking at their meetings:

1. What are the hospital's goals?
2. Are we meeting community needs?
3. What is it that we want the public to know about our hospital and its present and future plans?
4. What should the public do to help us?

We formed joint committees of the board of managers, medical staff and administration to discuss these questions, and we asked the nurses' alumnae, the women's auxiliary and the hospital personnel for their recommendations. About two years ago our thinking was finally crystallized and we decided that in order to meet community needs it was absolutely necessary for us to inaugurate a building program and to organize a new Department of Rehabilitation.

The next decision confronting us was: "Who should organize the public relations program necessary to the attainment of our goals?" There were many meetings during which the pro's and con's were set forth as to whether we should attempt the program with our own personnel (together with cooperation from the medical staff, the nurses' alumnae and the women's auxiliary) or whether we should seek expert advice. We decided to employ specialists, and entered into a contract with a nationally-known public relations and fund-raising organization. It would seem from our experience and that of others that an important step in the organization of a public relations program is to make "public relations" a permanent hospital department and to employ someone as director who has had experience and education to qualify him for the position.

It is well for us to remember that even though we place the responsibility for our public relations activities in the hands of a department head or specialists in the field, the administration and all hospital personnel still must carry responsibility for maintaining good public relations attitudes throughout the organization. In order to achieve good results, all personnel must take sincere and positive interest in the part they are to play in the public relations program.

Everyone should know that the Public Relations Department is the sole focal point for publicity, releasing news concerning hospital activities, for publication of periodicals, and the clearing of dates for special events and programs. This procedure is necessary so that there will be proper coordination of activities and no duplication of effort.

As soon as our counsel—members of the national fund-raising organization—came to the hospital, they set about making an appraisal of facts concerning our hospital and its service. They investigated first our human relations both inside and outside the hospital.

The public relations counsel and the administration met with those personnel and groups closely connected with the institution. We held meetings with the medical staff, women's auxiliary, nurses' alumnae, hospital personnel and students. During these meetings, we informed everyone about our plans for the future. The response was gratifying. Internally, the hospital was strong. Internal relationships—those with the hospital "family"—were of the highest order, so our public relations in this regard were excellent.

We have always had a public relations program, but certainly not as intensified or as comprehensive as that in which we are now engaged. During our 90-year service to the community we had participated in community functions in such manner as to bring to public attention the work of our hospital. Our press relationships had been very good over a long period of time. But we had not done enough, and it was not under the guidance of professional counsel.

The board of managers, administra-

tion and public relations counsel next met to discuss the public's acceptance and knowledge of the hospital. Was it well known in the community? Did the public know that we were a large voluntary non-profit general hospital in Western Pennsylvania? Were most community leaders aware of our accreditation? To our utter surprise, we learned that although we are conducting a large, accredited school of nursing, and training doctors in all the major medical and surgical specialties for which we have approval—offering an approved rotating internship, teaching medical students and training technicians—little of this was known by the general public. Although the hospital records during the past ten years showed over 110,000 operations, 131,000 anesthesias, 100,000 emergencies and 25,000 births, it was generally known by the average lay person as a hospital for the care of mentally ill.

It is true that the hospital has stood alone since 1878 in conducting a division for the care of the mentally ill, but this is only one department of the general hospital. Instead of this important public service resulting in good public relations, it brought about adverse considerations that were to the hospital's disadvantage. This was particularly unfortunate because we discovered that the men comprising the community's top leadership were mainly the ones who were misinformed about the hospital. At this point, we knew that it was time for us to take the initiative and present our case to create widespread interest, understanding, acceptance and, ultimately, support.

What were our patient relationships? To obtain the answer to this question, we sent out over 1,000 questionnaires to former patients. The questions we asked pertained to the comfort of room, noise, disturbance by other patients in the room, hospital odors, attendance and courtesies on admittance, receiving of visitors, explanation of treatments, food, mail service, changing of linens, etc.

The returns of this survey were satisfactory and encouraging. The replies pointed out (and helped to prove) what the administration believed, that care and treatment at St. Francis General were excellent.

Further analysis, based on independent investigation, revealed that in public relations, the hospital had both assets and liabilities. The good points showed that we were rendering essential service to the community and that the hospital was needed. It revealed also that in order to continue to meet community needs it was imperative for the hospital to expand its facilities. A hospital must rise to community demands; it should be flexible, ready and prepared to meet emergencies. For instance, recently by agreeing to admit to the hospital mentally-ill patients who were being referred to the city police department and admitted by them to the city jail, the hospital fulfilled a crying community need. The survey pointed out that the hospital is referred to as a "friendly hospital with a soul," and that it is noted for good patient care and for its policy of not asking for payment in advance. The relationships between the board of managers, administration and the medical staff are excellent.

On the liability side, despite the fact that the board of managers was

active and interested in the hospital, the hospital lacked top community leadership and it was evident that a community educational program was sorely needed. As mentioned previously, despite the fact that the hospital is rendering general hospital services, many referred to it as a mental institution (in spite of a daily waiting list of 200 medical and surgical patients).

Knowing the facts about the public's opinion of a hospital and coping with the issue involved are important phases in the hospital's public relations program.

In order to create a better understanding and greater appreciation of the hospital's work, we decided to change the name from St. Francis Hospital to St. Francis General Hospital and Rehabilitation Institute. The local newspapers gave this change wide publicity and one of the papers carried an editorial on rehabilitation and our plans for the future.

We intend to tell our story to everyone, beginning with small groups which in turn will tell others what they have learned about the hospital until, ultimately, we reach all in our area.

The women's auxiliary is a productive field for this type of "word of mouth" education, so we enlarged the membership and increased its activities. They had been a loyal and helpful group through many years, but there was much more they could do to help the hospital.

When we held a membership drive, the women interested friends in the auxiliary and we sent letters inviting prospective members asking them to join. At this date over 500 women are members—more than double the number we had two years ago.

The next step with the auxiliary was to institute a volunteer service program for the hospital. Although the auxiliary had been organized some 16 years before, this was the women's first opportunity to perform to any degree services in the hospital.

Now in uniforms of "cherry red," some 300 members are staffing such volunteer services as: information desk, messenger and escort, baby photo, free library, television for patients, sewing, portable gift cart, and clerical aid.

Our program of public relations utilizes newspaper releases as well as radio and television announcements. There are several excellent mailing pieces and a brochure which tells the hospital's story—past, present and future.

We realized that our problem was one of public education as well as public relations. The usual discussions took place concerning media which would best tell the story, and the one upon which we should place greatest reliance.

We were faced with many problems unique and native to our own particular situation, and we decided that we could best present our story community-wide through the vehicle of a documentary film, so audiences could see that hospitals, by their very work, are dramatic.

The film is divided into four parts. After the opening, which sets the tenor of the film, a period is devoted to hospital problems and management. Next there is a broad but concise account of problems confronting all general hospitals, such as construction needs,

(Continued on page 101)

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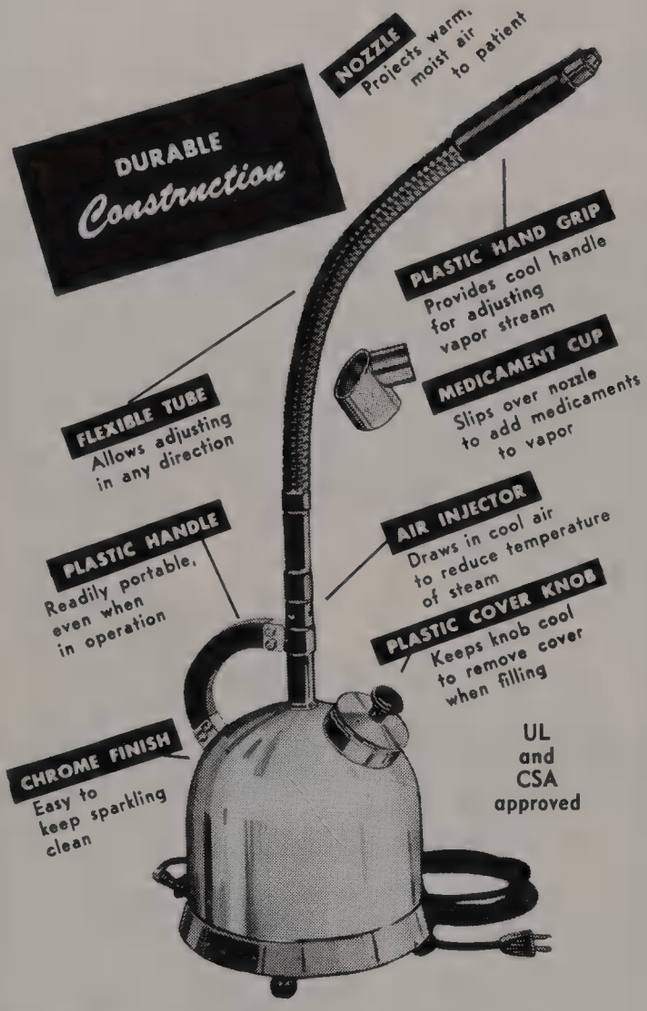

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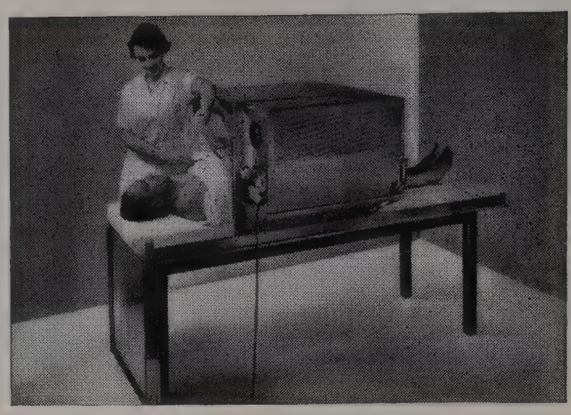

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Suturing Notes, O.B. Complications, Coding, Relaying J.C.A.H. Changes

LATE LAST YEAR a questionnaire was circulated to medical record librarians in an attempt to discover what material should be featured in this department of HOSPITAL PROGRESS. While the results have not been fully tabulated, it is evident that the majority approve of a "Question and Answer" approach to some of our problems. Accordingly, we will feature each year at least four sections which use this format. Sister M. Servatia, S.S.M., C.R.L., director of the Department of Medical Record Library Science, Saint Louis University, has kindly consented to act as consultant and to assist in preparing the material.

Q. *Is it necessary for surgeons to prepare an operative note for extensive suturing performed in the emergency room?*

A. A special form requiring the usual identification data is usually used in admitting patients to the emergency service. This form should also provide ample space for recording the treatment given. In cases where no further hospitalization is required, such a form should be adequate, assuming of course that the physician does clearly describe the procedure used in treatment.

Q. *We are a small general hospital with an average yearly discharge rate of about 8,000 patients. The coding is done by the workers in the Medical Records Department, along with the indexing. What might be considered an average number of charts which may be indexed and coded in one day?*

A. This is difficult to answer specifically. A great deal depends upon the physicians and whether they add all diagnoses made on patients or whether they state only the condition which resulted in admission. In all probability, it is the coding that consumes excessive time, and again the conscientiousness of the staff members influences the effort required. If the diagnostic terms they record require a great deal of checking through the record, and finally must be decided "by guess and by gosh," much time is wasted.

Perhaps the following suggestions will prove of value. Prepare a small handbook for the common codes, arranged alphabetically. About 75 per cent of diagnoses in a general hospital occur weekly or monthly. Prepare the codes for these common diagnoses in a manner that requires little research and lends itself to ready reference.

Perhaps the best way to determine the number of cases which can be coded in a given time is to do the job yourself for a given period, using typical cases. Weigh this figure by evaluating the formal preparation, competence and experience of those assigned the task and establish standards.

[Note: Sister Servatia wisely declined to commit herself as to any definite figures, but even though admittedly ignorant of these things, I will rush in to venture an opinion: Where personnel can index and code between ten and fifteen cases an hour, they are doing a good job (if the records are prepared as they are in the average general hospital). Let us have your comments. C.E.B.]

Q. *Where should a mother admitted with a threatened miscarriage or other complications of a five- or six-months' pregnancy be admitted? How should the case be classified?*

A. To answer the second part of the question first, it is acknowledged that from the time of conception until six weeks after delivery, a woman is correctly classified as an obstetrical case. When a pregnancy terminates as early or as late as at 20 weeks' gestation, the products of conception should be listed as a stillbirth rather than as an abortion. (Physicians' Handbook on Death and Birth Registration, 10th ed.).

Many hospitals, including some larger hospitals in the East, classify cases of early abortion (before 20 weeks' gestation) as gynecological, and also put them in the gynecological division. There are several reasons why this custom prevails in some hospitals. One is that sometimes these cases are complicated, have some medical condition, or an infection is present. If it is not possible for the hospital to have complete and adequate

CARE—OR COST?

Hospital care is a bargain financially. But any price is too high for a person without money. Hospitals face a double challenge: to explain the values of hospital service, and to develop orderly ways of financing care through group prepayment for those who have jobs, and public support for those who do not. [From: *News Letter* of the Hospital Council of Philadelphia]

facilities in the obstetrical division to separate these cases from the regular uncomplicated maternity cases, it is easier to assign such cases to the gynecological division.

Another reason might be that the nursing care of such patients is quite different from the regular obstetrical case and, should a student nurse on obstetrics chance to have a great many of these cases during her experience in that division, she would not receive properly comprehensive training. Also, some hospitals are forced to transfer to the gynecological division all mothers whose pregnancy does not terminate in a live birth, because there are too many mothers on the obstetrical division. (However, this condition does not change the nature of the case or make the pregnant woman a non-obstetrical case.)

This is a question that should be decided by your medical staff and not by nursing supervisors.

Q. *Is the medical record librarian responsible for informing the administrator and the medical staff of the various changes and modifications made by the Joint Commission on Accreditation of Hospitals in the Commission's Manual, rating system or bulletins?*

A. Technically, no. The administrator is responsible for the operation of all phases of the hospital. However, if the profession is to continue to grow in stature it is essential that you voluntarily assume responsibility for an increasingly larger share of what might be called administrative duties outside your own department. Every medical record librarian has a duty to be well informed about any subject that directly or indirectly affects her department, and if she wishes to be considered an executive rather than a technician, she must interest herself in anything that affects the hospital as a unit. In practice, most administrators rely upon the record librarian not only to study and analyze these recommendations, but to inform them about any changes. The administrator in turn should acquaint the medical staff through prescribed channels.

The increasing complexity of hospital administration represents a challenge to record librarians.

Bulletin No. 10 of the Joint Commission, distributed in January, answers many questions about the content of records. These recent changes are discussed on the Administrative Forum page in the next issue. ★

BOOKS

Nursing Manual for Psychiatric Aides

Edited by Anne Laurie Crawford, R.N., B.S. and Virginia Curry Kilander, R.N., B.S., M.Ed. F. A. Davis Co. 1954, 1st printing. Pp. 93

■ THE MANUAL IS CONCERNED with prevention, treatment and rehabilitation in mental illness. The authors have collaborated to make comprehensive material simpler and more understandable. The edition may be used in conjunction with formal lectures or textbooks, and may be adapted according to the needs of the individual student. Because of the wide variation in educational background among this group of nursing personnel, such usage will be dependent upon the clinical situation wherein the aide is working.

Every effort is made in the presentation of information to promote therapeutic relationships, yet basic facts elementary to good patient care are not wanting. It is to the aide that the major portion of nursing care of the mentally ill is allocated. The suggestions for direct patient care are excellent and should stimulate the translation of knowledge into practice.

This edition should impress all members of the psychiatric team with the necessity of concerted participation. General statements, preventive aspects and factual knowledge adequate for the usage of in-service education make the manual a particularly useful adjunct in training psychiatric nursing personnel.

The manual is a valuable handbook for basic preparation and should motivate nursing to more understanding care of the nation's largest category of ill. All content seems applicable to the Christian concept of promoting spiritual, mental and physical health.

—SISTER MARY JOHN ROBINSON, D.C.,
Director of Nursing Education,
DePaul Hospital, New Orleans, La.

Guard all the freedoms of democracy as you guard your life, but never forget that to abuse them is to destroy them. —Eric Johnston.

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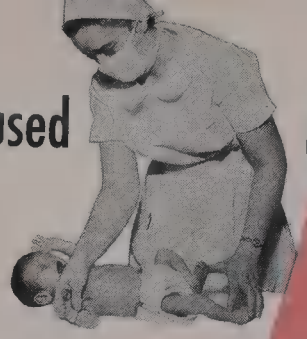

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For use in surgical cases, blood transfusions, the emergency room and in multiple-bed rooms—a never failing "double check" for complete accuracy—a protective procedure patients are glad to pay for.

Safe . . . Can't slip off. So sure, so trustworthy that it must be cut off.

Fast . . . Easy pressure of fingers snap-locks bracelet onto patient's wrist. No awkward tools or gadgets needed.

Comfortable . . . Soft, pliable, non-toxic plastic conforms to wrist. Won't impair circulation.

Attractive . . . Beautiful pink, blue and white plastic. Parents invariably want to buy bracelets as keepsakes—so they pay for themselves.

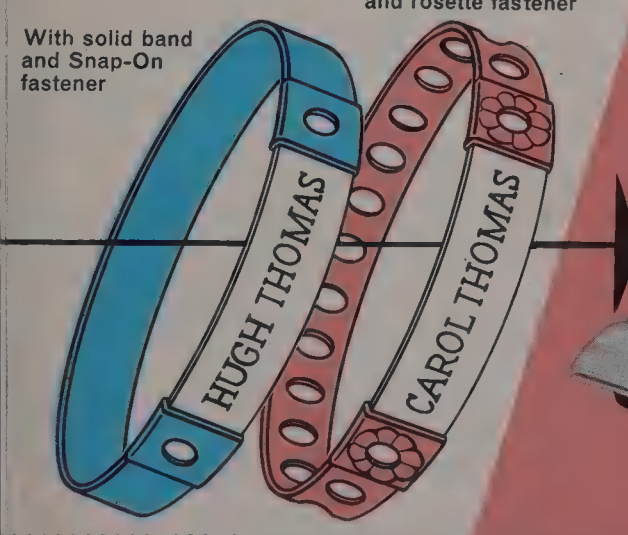
*Only **3** Simple Steps!*

1. *Write desired information on pre-cut card.*
2. *Slide into transparent holder.*
3. *Slight pressure of nurse's thumb and finger snap-locks bracelet onto patient's wrist. It takes only seconds!*

Available in two types...

With adjustable band and rosette fastener

With solid band and Snap-On fastener



Presco Baby Kit:
144 complete bracelets
(72 pink and 72 blue) [illegible]

Presco Adult Kit:
144 complete bracelets
(All pink, all blue, or all white) [illegible]

Presco Refills:
144 baby or adult style bracelets [illegible]

Packed In Attractive, Re-usable Kit!

For **Free** Samples, write
PRESCO COMPANY, INC.
Hendersonville, N. C.

Order from any one of these Distributors

AMERICAN HOSPITAL SUPPLY CORPORATION
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A. S. ALOE COMPANY
1831 Olive Street, St. Louis 3, Missouri

WILL ROSS, INC.
4285 N. Port Washington Rd., Milwaukee 12, Wisconsin

MEINECKE & COMPANY, INC.
225 Varick St., New York 14, New York

4 reasons why Presco

Feather-lite SCREENS are the Easiest-to-Handle and Safest!

1. So "feather-lite" that you can easily lift it with one hand.
2. Self-locking hinges lock panels into correct position. Perfect balance and floor-skids make screen virtually tip-proof.
3. Folds to 3-inch thickness for compact storage.
4. Handsome vinyl panels present a fresh, modern appearance. Snap-out rods mean easy removal for cleaning. Aluminum is anodized for lifetime satin finish. Also available with handsome gold finish ($5 extra).

3-Section Regular Model $34.50
3-Section Deluxe Model $44.50
Prices effective November 1st

There's a Presco to fit your needs

Presco offers a complete line of screens specifically designed for hospital service. A wide selection of models in 3 or 4-section styles, including the PRESCO Deluxe Screens (¾ inch tubular frames) and Regular Screens (½ inch tubular frames). Panels available in pastel blue, rose, green, white or circus motif for nurseries.

Disposable Bassinets

Help Reduce Cross-Infection —Ideal for sick babies and healthy babies —The solution to overcrowded nurseries

PRESCO *Disposable Bassinets are made of strong, rigid, water-resisting Flute-wood stock. Lightweight yet sturdy, one-piece construction . . . decorated in either pink or blue designs.*

Delivered flat and can be folded and assembled in one minute.

Please specify color or colors desired.

	East of Rockies	West of Rockies
In lots of 18 to 72	$1.75 Each	$1.83 Each
In lots of 90 to 216	$1.55 Each	$1.63 Each
In lots of 231 or more	$1.45 Each	$1.53 Each

Packed 18 pink or blue to a carton (wt. 85 lbs. per carton).

- **No Scrub-Up — No Disinfecting**
- **No Liners — No Re-Use**
- **Fits Most Standard Bassinets**
- **Parents Love to Take Them Home**

Parents are delighted to purchase this attractive Bassinet—so it more than pays for itself.

Order from any one of these Distributors

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MEINECKE & COMPANY, INC.
225 Varick Street, New York 14, New York

WILL ROSS, INC.
4285 N. Port Washington Rd.
Milwaukee 12, Wisconsin

PUBLIC RELATIONS

—Sister Adele

(Continued from page 93)

obsolescent facilities and currently increasing demands for service. The facts and figures are of a general nature and are applicable to any hospital in the nation.

The second broad division of the film deals with St. Francis specifically and portrays the work of various departments (surgery, pediatrics, obstetrics, physical medicine, electrocardiology, neuropsychiatry, x-ray, anesthesia, dietary, laboratory, laundry, central supply and others). In addition, we have mentioned the role of hospital personnel and volunteers.

The third section is devoted to the hospital's role as a teaching institution for medical students, nurses and technicians, with attention to the research activities of the hospital and the prominent staff physicians whose techniques and methods have gained national and world-wide recognition.

The fourth and closing division tells about the hospital's expansion program, proposed facilities and plans for the future.

The title of the film, *City Within a City*, makes an analogous comparison and alludes to the complexity of operation and magnitude of departments which make up a hospital. Produced in color and accompanied by narration, the picture runs approximately 24 minutes.

Just three months after we laid the groundwork for producing the film, we scheduled a première for selected community leaders, representatives of the press, radio and television. The response was enthusiastic, and the following day the reporters gave the film splendid publicity. On the same evening, we had a preview of the film for the medical staff. Then we distributed posters through the hospital announcing a special series of screenings for all personnel. The women's auxiliary and the nurses' alumnae also viewed the production at their regular monthly meetings.

To inform the general public that the film was available, we prepared a mailing piece, giving pertinent background data, which we mailed to all clubs and organizations and to a selected list of business and professional people in the city and surrounding area. For convenience, we enclosed a

return postcard so that those interested could request dates for showing.

To supplement the work of the information piece we took other steps to procure the film engagement before clubs and organizations. We sent a letter to each member of the medical staff, nurses' alumnae and women's auxiliary requesting them to co-operate in obtaining film engagements wherever possible. We distributed a similar letter to all other hospital personnel.

Through periodic news releases in the local newspapers and spot announcements on radio and television, we keep the public informed about the film and its availability. To date, there have been over 225 engagements before organizations throughout the Pittsburgh area. Several engagements have been held elsewhere in Pennsylvania. and in other states.

We feel that the film has paid dividends in broadening public acceptance of interest in and support of our hospital. It has accomplished much which could not have been done solely through radio, television, newspapers and direct mail.

We have always to keep before our minds that we are but one of 26 hospitals in Pittsburgh and one of 43 in Allegheny County, and keep asking ourselves how the board and administration can interest lay persons further with the greatness of the institution and its plans for the future. One immediate need was to increase the membership of our hospital's board of managers which we accomplished by asking our present membership to invite other prominent citizens to serve.

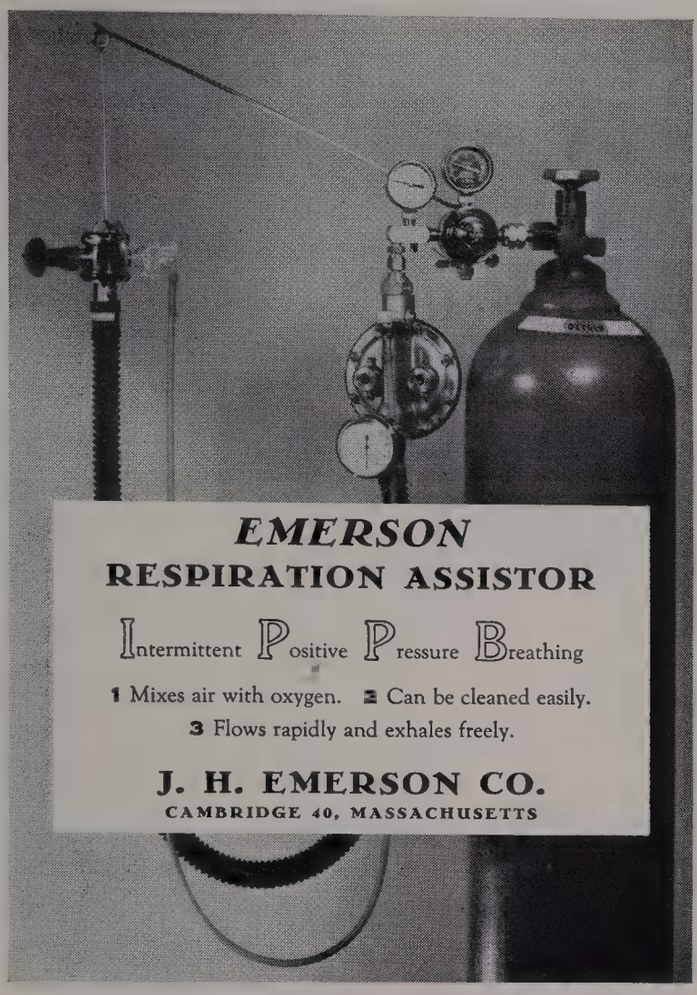
The Public Relations Department, working with the board of managers, went a step further and organized a Community Advisory Committee. This group is representative of business, management and labor. We sought the most outstanding person in the community to serve as honorary chairman. It required many months before we were able to interest him in our work and plans. After he finally became aware of the magnitude of the hospital's building program and its vital need to the community, he accepted the chairmanship. Through this person, 25 other industrial and business leaders were prevailed upon to join the Community Advisory Committee. This committee's function is to assume responsibility for our building fund campaign. It will in no way usurp the functions and duties of the hospital's board of managers.

We have completed the first phase of our campaign for funds—that is, among the hospital family group. The results were "over the top" and far beyond goals and expectations.

The community-wide campaign will take place this year. We have every reason to hope for success.

We encountered other problems and decisions in our public relations program such as lack of office space within the hospital, and expenses. But these are questions every organization will have to answer on an individual basis.

When we have accomplished our present goals, it will be necessary to re-evaluate the entire program so we can plan advantageously for the future. We are aware that a sound foundation for a good public relations program is one of education, requiring time and constant change, in order to keep before the public the ever-recurring needs of hospitals. ★



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RESPIRATION ASSISTOR

Intermittent Positive Pressure Breathing

1 Mixes air with oxygen. 2 Can be cleaned easily.
3 Flows rapidly and exhales freely.

J. H. EMERSON CO.
CAMBRIDGE 40, MASSACHUSETTS

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"Open-Type" UNITS OFFER MAXIMUM SPACE SAVING

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SAVES SPACE!
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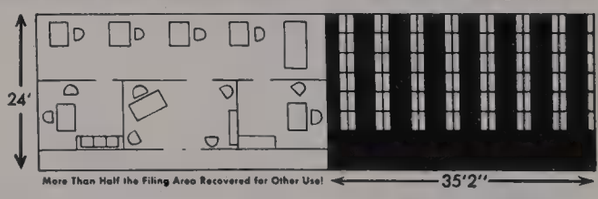
INCREASED EFFICIENCY

HIGHER EMPLOYEE MORALE

Floor Plan of an Actual Filing Area Before Installation of the Visi-Shelf Filing System

This area was occupied by 196 four drawer letter filing cabinets with a filing capacity of 784 drawers or 20,776 filing inches.

Floor Plan after Installation of the Visi-Shelf Filing System



90 Visi-Shelf Filing Units, occupying less than half the original filing area, hold all of the records previously filed in the entire filing area! These units, with a filing capacity of 25,380 filing inches offer 4,604 more filing inches — an increase of 25% in filing capacity.

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New Supplies and Equipment

Color Camera Attachment in Major Operating Lights

A COLOR CAMERA ATTACHMENT for mounting a 35mm camera in the lamphead of its new major operating lights, has been announced by the Wilmot Castle Company.

According to the manufacturer, the emergency device provides for the instant availability of photographic equipment in surgery in the absence of the usual photographic facilities. For the first time, the surgical staff is thus given a practical, simple means of obtaining color transparencies for evidence or record purposes.

Mounted directly in the lamphead of the new Castle No. 62 or 61 Lights, the attachment houses a Kodak Retina IIIc Camera, for the taking of either 20 or 36 separate exposures. Cameras are easily and quickly detached from the unit for other picture taking purposes. Cameras and necessary telescopic lenses must be ordered separately from a Kodak photographic dealer.

Professional assistance is not needed to operate the camera. Minor adjustments of the surgical lamphead or table superimpose built-in focusing rangefinder spotlights at the center of the field, assuring perfect focus, finest detail in every picture taken.

One control knob winds film within camera, cocks and trips shutter for exposure. Lens settings are pre-set—need never be touched if camera remains in light: double exposures are impossible.

Color-correction and intensity of the operating light, says the manufacturer, are so regulated that no additional lights, reflectors, or filters are required for color photography.

Wilmot Castle Co.
P.O. Box 629
Rochester 2, N.Y.

Perforated Door Available for Laundry Tumblers

ANOTHER NEW DEVELOPMENT has been made by Purkett Mfg. Co., in their 48″ Pre-Drying Conditioning Tumblers, by the addition of a perforated door which permits the operator to get another load ready and placed in the tub, while the tumbler is in operation.

Heretofore, the tub was kept over the open end of the tumbler after a load had been put in, to keep any of the garments or flat work from spilling out while rotating. This made it impossible to have another load ready and waiting to be put in the tumbler.

The door is synchronized with the operating of the tumbler so that when it swings over to the unloading position the door raises automatically. When the tumbler returns to the loading position, the tub with the new load is swung up to drop the load in the tumbler; then the door is swung into place when the tub returns to its loading position.

The company announces that the door is optional equipment on the 48″ size machine. They also advise that new and 4″ deeper, perforated tubs (16½″ total depth) are being used so that they can accommodate the load easier and without spilling over the top.

Purkett Mfg. Co.
Joplin, Mo.

"Pushbutton" Absorption Refrigerating Machine

A BRAND-NEW LINE of large capacity automatic "pushbutton" absorption refrigerating machines which produce chilled water from steam has been announced by Carrier Corporation.

Available in a full range of sizes from 100 to 700 tons, the absorption units are used in air conditioning and process cooling systems. The machines have no major moving parts, and employ plain water as the refrigerant.

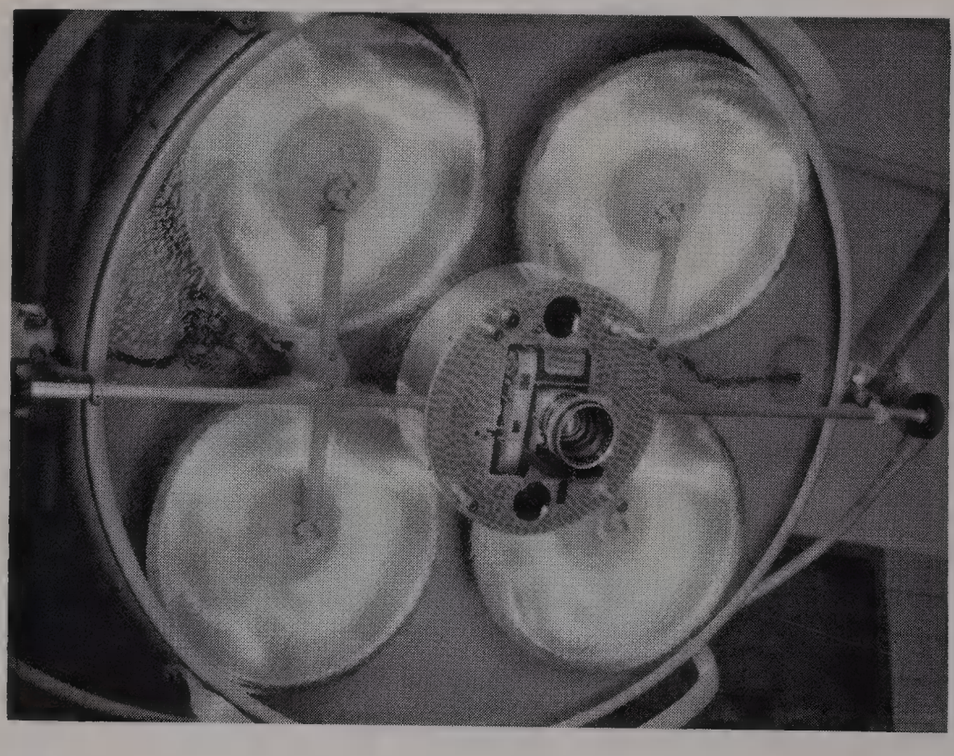
Overloading will not hurt the Carrier absorption machine. In the event that cooling beyond design capacity is required, the machine will continue to operate, delivering additional tons of refrigeration, at a higher than design temperature level. There is nothing about the unit that can be damaged by overloading.

The machine is particularly economical to operate wherever a low-cost source of heat, such as natural gas, is available to provide steam. Low pressure steam may also be obtained from back pressure turbines or from exhausts from various processing operations. This waste steam may be used to provide chilled water at little operating cost.

Although steam is most generally employed, any hot fluid, such as hot water, oil or chemicals, may be used to generate cooling in this Carrier unit.

The new design eliminates many of the major service lines and all of the external auxiliary piping normally assembled at the job site, thus substan-

New Operating lights by Wilmot Castle provide camera attachment



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Technicolor or Black and White. 82 Minutes. Starring Tony Curtis, Colleen Miller.

A-1 FRANCIS IN THE NAVY

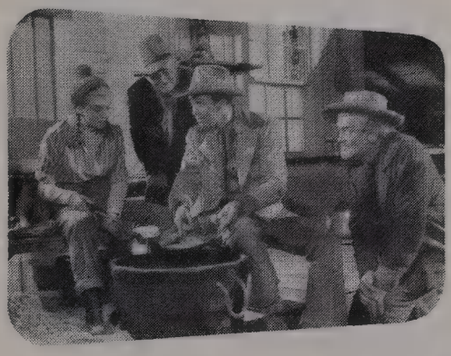
Black and White. 80 Minutes. Starring Donald O'Connor, The Talking Mule.

A-1 THE PRIVATE WAR OF MAJOR BENSON

Technicolor or Black and White. 105 Minutes. Starring Charlton Heston, Julie Adams, Tim Hovey.

A-1 THE GLENN MILLER STORY

Technicolor or Black and White. 116 Minutes. Starring James Stewart, June Allyson.



A-1 THE FAR COUNTRY

Technicolor or Black and White. 97 Minutes. Starring James Stewart, Ruth Roman.

A-1 MA AND PA KETTLE AT WAIKIKI

Black and White. 79 Minutes. Starring Marjorie Main, Percy Kilbride.

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tially reducing the time and cost of installation. The new machine is distinguished by clean, handsome styling —an innovation for a large refrigerating unit.

Carrier Corporation
Syracuse 1, N.Y.

Electrically-Heated Portable Coffee Urns

NEW ELECTRICALLY-HEATED VERSIONS of the popular gas-heated Tri-Saver Jr. and Sealweld Jr. coffee urns are now available from S. Blickman, Inc.

These urns provide their own hot water supply in sufficient quantity to assure maximum capacity for coffee or tea. There are two standard sizes: three gallons of coffee with five gallons of water, or five gallons of coffee with eight gallons of water.

Tri-Saver Jr. and Sealweld Jr. urns are or all welded-stainless steel crevice-free construction with leak-proof seams. Features include cool, plastic handles for covers and faucets, metal gauge glass protectors and heavy-duty, non-drip stainless steel faucets.

Installation and maintenance costs are low. Disassembly for cleaning purposes can be done without tools in a matter of minutes, by removing the coffee faucet. Liners are of stainless steel with bottom sloped to a tangent draw-off, assuring full drainage.

The electrically-heated Sealweld Jr. Urns (with urn bag and ring) sells for $207—3 gallon size; $231—5 gallon size, and the electrically-heated Tri-Saver Jr. Urns (with permanent Tri-Saver filter) sells for $246—3 gallon size; and $270—5 gallon size.

Urns are supplied with 2500 watt heavy-duty immersion heater and thermostat for 110 or 220 volt, single phase, AC operation only. Electric cord and plug are furnished. Self-closing water inlet valve is available at an extra cost of $21.

These selling prices are f.o.b. Weehawken, N.J., and do not include state, municipal or other use taxes.

S. Blickman, Inc.
Weehawken, N.J.

Lacta Breast Pads by Seamless Rubber Co.

A NEW IMPROVED BREAST PAD to be marketed under the name of Lacta Breast Pads, has been introduced by The Seamless Rubber Company.

Anatomically shaped for maximum comfort and freedom from pressure, Lacta is made of soft absorbent cotton which is non-irritating. A non-absorbent facing with a fully sealed circumference rim prevents seepage.

Made to fit specifications as given by physicians, Lacta Breast Pads are available through surgical supply dealers and are packed 12 per box.

The Seamless Rubber Company
New Haven, Conn.

Automatic Venting Stopper by Fenwal Laboratories

A FLANGE-TYPE RUBBER STOPPER for bottles that permits autoclaving of fluids is a new device created and produced by Fenwal Laboratories, Inc. The new stopper gives hospitals that manufacture their own intravenous solutions, a simpler and more convenient bottle closure.

Designed specifically to fit the Upjohn bottle, now being distributed solely by Fenwal Laboratories, the stopper contains a hole for insertion of Fenwal Intravenous Set or a Fenwal Recipient Set. It also has a self-closing vent aperture, which makes possible automatic venting during administration of fluid.

Since the stopper can be re-used, the economy factor is another of its im-

portant features. Recent tests show no change in performance after 17 re-sterilizations and the researchers feel it can be re-used many times over that figure.

After the bottle is filled, the automatic venting stopper is inserted. The cap is next placed loosely on the bottle. Bottles are then autoclaved according to usual procedure after which caps are screwed down to seal the bottles. When the solution is to be administered, the cap is removed and the spike of the administration set is inserted in the outlet hole of the self-venting stopper.

Fenwal Laboratories, Inc.
Framingham, Mass.

Time Autoclave Labels by Professional Tape Co.

SETS OF NEW SELF-STICK LABELS complete with standard nomenclature are available for nursing, central service, lab, pharmacy, solutions, and blood bank departments. These Time Autoclave Labels are designed to save time and standardize procedures.

In nursing they will simplify collection of specimens and insure having all correct data; in central service they are ideal for sealing and labeling articles in one quick operation. Colored labels for coding diets or infant feeding are also available.

Time labels are paper-coated with a special vinyl plastic to resist steam and heat during sterilization. They come in roll form and are dispensed from metal holders. A six-page folder "Hospital Labeling Procedures" and a free sample are available on request.

Professional Tape Co.
Box 41 F
Riverside, Ill.

"Mannikin" Simplifies Teaching of Congenital Heart Disease

THE NEW CARDIAC "MANNIKIN" unit consists of a two-dimensional plastic "cutout" of the heart and great vessels, including vascular supply to the lungs. The regions of the aortic arch and the root of the aorta and pulmonary artery are removable units. Selection of a number of interchangeable pieces permits the nature of the cardiac lesion to be changed by a simple replacement maneuver.

The basic unit is made of ¼" plastic (approximately 18" in its longest diameter) fused to a background plate of frosted Plexiglas (20" × 24"). Light source is two fluorescent tubes within the viewing box. Interchangeable pieces are also of ¼" plastic; plastic pegs on the back of these pieces fit into holes aligned in the frosted Plexiglas background.

Coloring is the conventional red and blue. The viewing box is a self-contained unit; it is its own carrying case. Its cover serves to protect the model and has space for the interchangeable pieces. Its size is adequate for auditorium teaching.

The Cardiac "Mannikin" is priced at $225. (Catalog No. MA-92759).

Picker X-ray Corp.
25 South Broadway
White Plains, N. Y.

Stille Needle Holders and Forceps

THE AVAILIBILITY of a new line of Stille needle holders with diamond-hard homogenous jaws has been announced by the Ohio Chemical & Surgical Equipment Co. (A Division of Air Reduction Company, Incorporated).

The jaws themselves engage the surgical needle firmly, thus completely

eliminating any tendency to slip, twist, scratch, or break. The well-balanced needle holder features dependable never-slip "Three-in-one" ratchets, insuring positive and comfortable operation of the instrument without undue physical effort or muscular fatigue.

It is available in 5½", 6", 7", and 10" normal jaw sizes and in 7" and 8" narrow jaw sizes.

Ohio Chemical also announced the availability of Stille-Bjork needle holders in 8" and 10" sizes, designed especially for thoracic surgery, but also useful in general surgery. These also have the special "Three-in-one" feature which permits the surgeon to do continuous suturing without having to engage or disengage the ratchets.

A companion item is the Stille-Crafoord knot tying forceps, available in 5", 7" and 8" sizes.

An illustrated folder describing the new Stille needle holders and forceps, is available by requesting form 4680.

Ohio Chemical
Madison 10, Wis.

Improved Sterilometer Gives Instant-Glance Readability

STERILOMETER LABORATORIES, makers of sterilizing indicator for almost a quarter of a century, have announced that a new feature gives Sterilometer more accurate "readability" than any other indicator.

When the new Sterilometer is removed from an autoclave pack, an "instant-glance" tells if that pack has been autoclaved and if it is safe for use. The new Sterilometer actually says "NOT Autoclaved" or "Autoclaved," whichever condition happens to be true. With this superior "readability," error in sterilization assurance is considerably reduced.

This new indicator continues to incorporate the established advantages and features perfected by Sterilometer Laboratories over a period of 23 years. It warns an autoclave operator against improper timing, insufficient steam pressure and faulty thermometers. Sterilometers still change from white to black only after the three essentials of sterilization (time, steam and temperature) have been met in the autoclave. However, through research and new production methods it is now possible to have the improved sensitive chemical obliterate the word "NOT" when it changes to black, so that the indicator reads "Autoclaved." If the proper conditions for sterilization have not been met in the autoclave, the Sterilometer will continue to warn "NOT Autoclaved"!

Free samples of the new Sterilometer are available.

Sterilometer Laboratories
11471 Vanowen St.
North Hollywood, Calif.

Vollrath Stainless Steel Soup Cup and Cover

A 10-OUNCE SOUP CUP by Vollrath is attractively designed for individual tray service. The cover, which is interchangeable with china soup cups, may be purchased separately. Both cup and cover are solid stainless steel for permanent beauty, long-range economy, maximum sanitation.

The Vollrath Co.
Sheboygan, Wis.

PHARMACEUTICALS

E. R. Squibb & Sons

Mycostatin (nystatin), an antifungal antibiotic recently introduced for therapeutic use, is now available from the E. R. Squibb & Sons in a form suitable for use in tissue culture and for other laboratory purposes.

The new antibiotic offers for the first time an agent which effectively controls molds and yeasts but is non-toxic to tissue cells and viruses. It has been of value in experimental or vaccine production of many viruses, including those of polio, hoof and mouth disease, influenza, African encephalitides, and herpes simplex.

For laboratory use, the material is supplied as a finely-divided sterile powder which forms a suspension in aqueous media.

Detailed information on the use of Mycostatin in the laboratory is contained in a bulletin entitled "Laboratory Applications of Mycostatin," available from the company's Professional Service Dept.

Chas. Pfizer & Co.

A new dosage form of the synthetic crystalline steroid hormone, Sterane (prednisolone), an analog of hydrocortisone, is now available in 1 mg. pink tablets.

It is for treatment of rheumatoid arthritis, hay fever, bronchial asthma, pemphigus vulgaris, acute disseminated lupus erythematosus, exfoliative dermatitis, atopic dermatitis, ulcerative colitis, periarteritis nodosa, scleroderma and dermatomyositis.

In clinical trials, Sterane has proved

to be three to five times more potent than hydrocortisone or cortisone as an anti-rheumatic or anti-inflammatory agent. It is similar to cortisone or hydrocortisone in suppressing rheumatoid arthritis, but is quantitatively superior and relatively free of significant metabolic, water or electrolytic disturbances.

It is sold in bottles of 100 tablets, each containing 1 mg. of Sterane.

SUPPLIERS' NOTES

Abbott Laboratories

George H. Berryman, M.D., head of the Department of Clinical Investigation at Abbott Laboratories, has been appointed to the interdepartmental Committee on Nutrition for National Defense.

Dr. Berryman will serve as a nutritional consultant to the committee which co-ordinates governmental departments studying the nutritional problems of countries allied with the United States in NATO and elsewhere.

American Hospital Supply Corp.

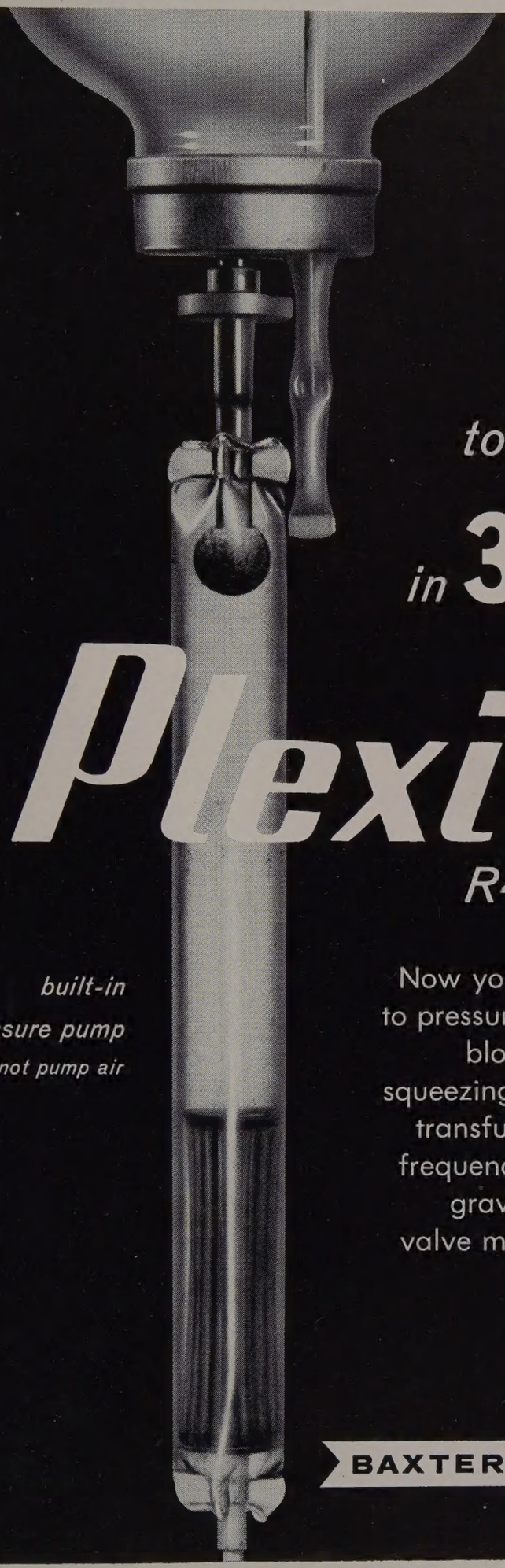
Mr. Gordon Hall has been appointed manager of the Los Angeles Division of American Hospital Supply Corp. He succeeds Mr. C. D. Summers.

Winthrop Laboratories, Inc.

The corporate name of Winthrop-Stearns Inc., has been changed to Winthrop Laboratories, Inc., according to an announcement by Dr. Theodore G. Klumpp, president.

Established in 1919 under the name of Winthrop Chemical Company, Inc., the business was consolidated in 1935 with H. A. Metz Laboratories. In 1942, Alba Pharmaceutical Co. was merged with Winthrop and, in 1947, Winthrop-Stearns Inc. was organized as the result of the acquisition of Frederick Stearns & Co., Detroit. ★

ADVERTISERS INDEX



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Now you can switch from gravity flow to pressure in 3 seconds...give a pint of blood in 4 to 5 minutes simply by squeezing flexible drip chamber. Rate of transfusion is controlled by force and frequency of squeeze action. Return to gravity flow at will. Unique safety valve makes it impossible to pump air.

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LEDERLE LABORATORIES DIVISION
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PEARL RIVER, NEW YORK

Heparin Repository Injection Lederle

A sterile preparation of heparin in a gelatin-dextrose menstruum. Each cc. contains 20,000 U.S.P. units. Provides immediate and prolonged effect in one dose. Contained in a convenient, disposable syringe. Because this preparation is free of acetic acid, it is less painful on injection.

Heparin Sodium Injection Lederle

A sterile, isotonic solution of sodium heparin. Available in two potencies: 1,000 U.S.P. units (approximately 10 mg. heparin) per cc. for intravenous therapy with 5% glucose, Ringer's solution, or saline; and 10,000 U.S.P. units (approximately 100 mg. heparin) per cc. for intramuscular therapy.